Evans Chiropractic Health Center
William M. Rice, D.C., P.C.
108 SRP DR STE A | EVANS GA 30809-3319 | 706-860-4001

RELEASE OF INFORMATION FORM

Patient's Name _____ Date of Birth ____/____/_____

Under federal law, we are permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

We may disclose health information to a member of your family, relative, close friend, or other persons identified by you to be involved in your healthcare or payment of your healthcare. We will limit the disclosure to only the protected health information relevant to that person's involvement in your healthcare or payment.

Any other use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization to release information **including** the diagnosis, records, examinations, and claims information rendered by our office.

I authorize the release of information of all my records, to include the diagnosis, examinations, and claims information to the following: (please check all that apply and list names)

- ☐ Spouse _____
- ☐ Child(ren)_____
  _____
  _____
- ☐ Other _____
- ☐ This information is **not** to be released to anyone.

I, the undersigned, have read and understand all of the above and have agreed to terms stated above.

_____ _____
Patient, Parent, or Guardian Signature Date

_____ _____
Witness Date