Rice Chiropractic Clinic

204 N. First St.
Conroe, Texas 77301
Fax: 936-756-2415/936-463-6170
ricechiropractic@me.com

Patient Name: _____

Soc. Sec. #: _____-_____-_____ Date of Birth: ____/____/_____

Hospital/Facility patient was seen:

- ☐ Conroe HCA
- ☐ St. Luke's-Woodlands or St. Luke's Chi (circle correct one)
- ☐ Kingwood Hospital
- ☐ Huntsville Memorial
- ☐ Hermann Memorial-Woodlands
- ☐ Other: _____

Numbers for the Hospital/Facility you were seen:
Phone: _____ Fax: _____

For the purpose of treatment, I request and consent to the release of my complete health record. If there is information you want to exclude, please list:

_____

_____

This authorization for release of information covers the period of healthcare from:

- ☐ _____ to _____ (Date of accident: _____)
- ☐ All past, present, and future periods

I authorize Rice Chiropractic Clinic to use and disclose the protected health information described above for my medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I certify that the information above is true and that when releasing this Protected Health Information for the above patient you are releasing Rice Chiropractic Clinic of any liability and certify that under perjury of law you are who you say you are. This clinic complies with all applicable federal privacy statutes.

HIPPA Privacy Authorization Form ****Authorization for Use or Disclosure of Protected Health Information** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: _____

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Patient/Guardians Signature: _____ Date: _____

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