ABUNDANT LIFE
FAMILY CHIROPRACTIC
FUNCTIONAL MEDICINE SPECIALISTS

Dr. Brian K. Wehling
3919 S. 48th St.
Lincoln, NE 68506
Phone: 402-858-6130
Fax: 1-402-858-6513
reception@alfclincoln.com

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

NAME: _____ **DATE OF BIRTH:** _____

Address: _____ **Day Phone:** _____

City: _____ **State** _____ **Zip:** _____

Clinic/Hospital/Health Care Provider –

(***Who*** has the information you want released?) **Please list the specific Hospital and/or clinic.**

NAME: _____

Address: _____ **Day Phone:** _____

City: _____ **State** _____ **Zip:** _____

Fax:

Receiving Party

(***Where*** do you want the information sent? ***Who*** may have the information?)

NAME: Abundant Life Family Chiropractic **Attention to:** Brian Wehling, DC

Address: 3919 S. 48th St. **Day Phone:** 1-402-858-6130

City: Lincoln **State** NE **Zip:** 68506

Fax Number (URGENT PATIENT CARE ONLY) 1-402-858-6513

Information to be Released

(***What*** do you want sent or released? Check the appropriate box.)

Routine Record Sets **(indicate date(s) of service _____)**

- ✓ Clinic (office visit, lab, radiology, medicines, immunizations)
- ✓ Hospital (history and physical, discharge summary, operative report, consultations, emergency, laboratory, radiology)
- Billing Records
- Copies of Films/Images
- Community Pharmacy Charges
- ✓ Any and all records (includes ALL types of record listed below. If you want to include images and billing records, check those boxes.)

Only records types checked below:

Discharge summary/note	Radiology reports	Emergency record(s)	Medication records
History & physical exam	Rehab records (PT/OT/ST)	Immunization/allergy record	Chemical dependency/
Operative report	Laboratory reports	Pathology reports	Substance abuse records
Consultations	Progress notes/clinic notes	Mental health records	Pathology slides/blocks

Other records specify record type(s) _____

OPTIONAL Limits - Disclose only records related to following:
Date(s) of service/: injury or illness:

Release Instructions

(***How*** and ***When*** do you want the information?)

Date information is needed: _____ **(NOTE: PLEASE ALLOW 7-10 DAYS FOR PROCESSING)**

Release Method / Format requested: (check one)

Paper *CD/DVD* *View my Record* ✓ *Fax* (patient care only) 1-402-858-6513 *Verbal*

Continuing Care Information released by Nursing Station/Department (verbal and paper) **Yes** **No**

Purpose of Release

(***Why*** is it needed?)

✓ Continuing care	Transfer of care	Social security appeal
Insurance application *	Personal use or review *	Social security disability
Insurance payment/claim	Litigation/legal *	determination *
Other* _____		

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here:_____
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation.
- Abundant Life Family Chiropractic will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Abundant Life Family Chiropractic records may include records that it received from other organizations. If these records have been used by Abundant Life Family Chiropractic and filed in the in the record Abundant Life Family Chiropractic maintains about you, these records may be released with your Abundant Life Family Chiropractic Records.
- Abundant Life Family Chiropractic cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Abundant Life Family Chiropractic any and all liability resulting from a redisclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

_____ _____ _____

Patient/Legal Guardian Signature | Date | Authority to act on behalf of patient (attach document)