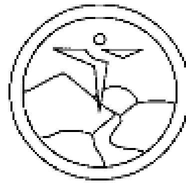
Akita Chiropractic
818 W. 6th Street, Suite 5
The Dalles, OR 97058
P: (541) 296-1900
F: (541) 298-7340



Timothy Akita, D.C.
Chiropractic Physician

AUTHORIZATION TO DISCLOSE PRIVATE HEALTH INFORMATION

Patient Name: ___________________________________

I hereby acknowledge, consent and authorize the disclosure of my health information from Akita Chiropractic, LLC to the family member or friend named below.

Name _______________________________________ Relationship ______________________

Phone number _________________________ Address ________________________________

Name _______________________________________ Relationship ______________________

Phone number _________________________ Address ________________________________

Please initial next to the type of information you authorize to release.

_________ My complete health record, including but not limited to laboratory tests, imaging, diagnoses, prognosis, treatments, appointments details, and financial information.

You may revoke this authorization at any time by providing a written request. To do so, please send a written statement to Akita Chiropractic, LLC at 818 W 6th Street, Suite 5, The Dalles, OR 97058.

I have read and understand this authorization. It will remain in effect from today's date until I choose to revoke it or until the specified date: _________________.

Patient Signature ____ Date: _____________

Or Personal representative _______________________________________ Date: _____________

Personal representative's authority ____