27850 Gratiot Avenue
Roseville, MI 48066
Phone (586) 772-5876
Fax (586) 772-1122

LUPO
CHIROPRACTIC LIFE CENTER, P.C.

12912 E. 8 Mile
Detroit, MI 48205
Phone (313) 527-7070
Fax (313) 527-7016

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

I hereby voluntarily authorize the use and/or disclosure of my health information as described below, to the requestor's listed below. I understand that if the organization authorized to receive the information is a healthcare provider, the information may be further disclosed and no longer protected by federal privacy regulations.

If not revoked earlier, this authorization shall terminate upon final resolution of all claims related to the claim number set forth below. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Provider. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by Provider. I also understand that I may receive a copy of this form. A photocopy of this authorization is as effective and valid as the original.

INSTRUCTIONS: Make sure all blanks are filled in. Failure to do so may prevent or delay release of information.

PATIENT _____ Name _____

IDENTIFICATION: _____ Date of Birth _____ Soc. Sec. _____

Parents/Previous Name(s) _____

PROVIDER: (Who is releasing the information)

- ☐ All Physicians
- ☐ All Hospitals
- ☐ All Other Health Care Providers, or Health Insurance Companies who have provided treatment, care or benefits to the above-named patient.
- ☐ Specific Provider_____
  I specifically authorize Requestor to insert the names of additional specific Providers, when necessary, to facilitate the purpose of this disclosure.

REQUESTOR: (Where do you want the information sent)

Name Lupo Chriopractic Life Center, P.C.
Address 27850 Gratiot Avenue
Roseville, MI 48066

INFORMATION REQUESTED:

- ☐ Complete Records In the Possession of Provider and / or Its Agent
- ☐ Specific Information (Please Specify) See 2nd Page

PURPOSE OF DISCLOSURE:

- ☐ At Request of Patient or Legal Representative
- ☐ Review and Processing of Motor Vehicle Insurance Claim (Claim # _____)
- ☐ Other _____

Doctors, hospitals and other covered entities under federal privacy regulations may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization. As part of this authorization for the release of medical, I specifically authorize the release of data and information relating to substance abuse treatment (alcohol/drug), mental health (includes psychological testing), HIV-related information(AIDS related testing) and sexually transmitted disease.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE _____ DATE _____

RELATIONSHIP TO PATIENT, INCLUDING AUTHORITY TO ACT AS REPRESENTATIVE, IF NOT SIGNED BY PATIENT