



# Active Spine & Rehabilitation

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J.D. Dorman, DC | Lance Fredrickson, DC | Wayne Huber, DC CCSP

## EXTERNAL AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I hereby authorize **Active Spine & Rehabilitation** to use or disclose my personal health information as described below. I fully understand that this authorization is voluntary. By signing this authorization, you are allowing **Active Spine & Rehabilitation** to release and/or receive my patient health information to and from other sources, including health plans, health care providers, and/or sports personnel. I also understand that if the organization or individual(s) that I authorize to receive my personal health information is not a health plan or health care provider, the released information may be re-disclosed and may no longer be protected by federal privacy regulations.

Furthermore, I request and authorize **Active Spine & Rehabilitation** to release and/or receive specified information from treatments at the given facility. Information released may include, but are not limited to: Medical Records, Medical Statements/Bills, Doctor Soap Notes, X-Rays, X-Ray Reports, Laboratory Reports, Operative Reports, and Pathology Reports.

I specifically request that the above personal health information be released to the following provider:

\_\_\_\_\_ Dr. Wayne Huber, DC CCSP

\_\_\_\_\_ Dr. Lance Fredrickson, DC

\_\_\_\_\_ Dr. J.D. Dorman, DC

At:

Active Spine & Rehabilitation  
101 W 69<sup>th</sup> Street, Suite 100  
Sioux Falls, SD 57108

I understand that I may revoke this authorization at any time by notifying Active Spine & Rehabilitation in writing. However, I fully understand that the revocation will not have any effect on any actions taken before the revocation is received by the clinic.

\_\_\_\_\_  
Signature of patient or patient's representative

\_\_\_\_\_  
Date

A photocopy of this authorization shall be deemed as effective as an original.