REQUEST FOR PROTECTED HEALTH INFORMATION (PHI)

TO: _____

_____

_____

Phone (_____)_____-_____

Fax (_____)_____-_____

RAY CHIROPRACTIC CENTER, PLLC REQUESTS THE FOLLOWING PROTECTED HEALTH INFORMATION ("PHI") TO BE FORWARDED TO OUR OFFICE AT THE ADDRESS GIVEN BELOW

NAME AND ADDRESS OF REQUESTOR

Ray Chiropractic Center, PLLC
62 North Stapley Drive
Mesa, Arizona 85203
Phone (480)964-1234 Fax (602)532-7526

Description of requested PHI:

- ☐ Medical Records (Including all intake forms)
- ☐ X-ray / CT Scan / MRI Films **WITH** any corresponding reports (CD if available)
- ☐ Blood / Lab Reports
- ☐ Other: _____

PHI is requested for the following purpose(s):

X Treatment (NOTE: disclosures for treatment purposes between health care providers are exempt from the minimum necessary requirements.)

- **Patient's Name**: _____
- **Patient's SS#** : ### - ## - _____
- **Patient's DOB**: _____

AUTHORIZATION

I _____, hereby authorize and request that you release the above requested information to Ray Chiropractic Center, PLLC at the above listed address.

Patient Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

Send Form