

Patient Authorization / Request for Release of Medical Records

Oler Chiropractic closed on May 29, 2026. Records remain securely maintained. Complete all applicable sections, sign page 2, and **email the completed, signed form** with a copy of your government-issued photo ID to **records@grovelandchiropractic.com**. Questions: 209-962-0662.

1. Patient Information

Patient full legal name	Other names used (maiden, previous)	
Date of birth (MM/DD/YYYY)	Phone	Email
Mailing address (street, city, state, ZIP)		

2. Person Making This Request

☐ I am the patient ☐ I am the patient's personal representative (complete below)

Representative's full name	Relationship / legal authority (e.g., parent, guardian, POA, executor)

Personal representatives must attach proof of authority (e.g., guardianship order, healthcare power of attorney, letters testamentary, or birth certificate for a minor).

3. Records Requested

☐ Complete chart ☐ Office / treatment notes ☐ Billing / payment records
☐ Other:

Dates of service FROM (MM/DD/YYYY)	TO (MM/DD/YYYY)

If no dates are entered, all available records within the selected categories will be released.

4. Release Records To

☐ Patient (self) ☐ Another person or provider (complete below)

Recipient name	Organization / practice
Recipient address	
Recipient phone	Recipient email

Delivery format: ☐ Email (electronic copy) ☐ Paper copy by mail

5. Purpose of Disclosure

☐ At the request of the individual / personal use ☐ Continuing care ☐ Insurance
☐ Legal ☐ Other:

6. Specially Protected Information (California) — Optional

Some information requires your specific authorization before it can be released. If your records contain any of the following and you authorize its release, **write your initials** in the box. If left blank, this information will be withheld where required by law.

Initials — HIV / AIDS test results (Cal. Health & Safety Code §120980)

Initials — Mental health / psychotherapy information (Cal. Civil Code §56.104)

Initials — Substance use disorder treatment records (42 CFR Part 2)

7. Expiration

This authorization expires on (date or event):

If blank, this authorization expires one year from the date signed.

8. Your Rights — Please Read

- **Right to revoke:** You may revoke this authorization at any time by sending a written request to **records@grovelandchiropractic.com**. Revocation does not apply to information already released in reliance on this authorization.
- **No conditioning:** Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether you sign this authorization.
- **Redisclosure:** Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy law (HIPAA).
- **Copy of form:** You have the right to receive a copy of this signed authorization.
- **Fees:** A reasonable, cost-based fee may apply as permitted by law; you will be told of any fee before records are sent.
- **Response time:** Requests are generally processed within the time frames required by law; California law (Cal. Health & Safety Code §123110) generally provides for copies within 15 days of receiving a complete request.
- **Legal basis:** This form is intended to meet the requirements of 45 CFR §164.508 (authorizations) and §164.524 (right of access).

9. Signature

I have read this form and authorize the release of the records described above.

Signature of patient or personal representative

Date signed (MM/DD/YYYY)

Adobe Reader: click the box to sign with a digital ID, or use Fill & Sign. Apple Preview: Markup > Sign, and place it in the box.

Typed signature (type full name to sign electronically)

Printed name

If signed by a personal representative: description of authority / relationship to patient

☐ I have attached a copy of my government-issued photo ID (required to verify identity).

Personal representatives: attach a copy of your own photo ID along with proof of authority.

OFFICE USE ONLY

Date received

☐ ID verified

Date sent

Sent by

Method sent (email / mail) and notes