

Donald W. Olson, DC, FASBE, DACS

'A' STREET CLINIC OF CHIROPRACTIC PLLC
1020 'A' Street SE, Suite 4
Auburn, WA 98002
(253) 939-0909

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name _____ Date of Birth _____

Address _____

I request and authorize _____
to release health care information for the above patient to:

'A' Street Clinic of Chiropractic PLLC
Donald W. Olson, D.C., F.A.S.B.E., D.A.C.S.
1020 'A' St SE, Suite 4
Auburn, WA 98002
Fax: (253) 883-3520

This request and authorization applies to:

_____ Medical Records All or _____

_____ Imaging with Reports All or _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

Signature of patient or patient's authorized representative Date

Relationship or status if signed by anyone other than the patient (i.e. parent, legal guardian, personal representative, etc.)

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED