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
(253) 939-0909

This request and authorization applies to:

_____ X-Rays Only

_____ Medical Records Only

_____ X-Rays and Medical Records

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