



**Dr. Donald Shiflet**  
Chiropractic Physician

**The Back Alley Chiropractic & Massage**  
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**Authorization to Use or Disclose Protected Health Information**

You have a right to receive a completed copy of this form. Photocopy/fax copy may be used as original. **Note to patient:** A FEE may apply to this request for records. Arizona law states we must process requests for records within 30 days of the request.

**PATIENT INFORMATION:**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Phone # \_\_\_\_\_

**FACILITY RELEASING INFORMATION:**

Name: The Back Alley Chiropractic & Massage  
Address: 1880 E Tangerine Rd Ste 110  
Oro Valley, AZ 85755-6241  
Fax: 520-877-9183 Phone: 520-877-2666

**TO WHOM INFORMATION IS BEING DISCLOSED:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

**RECORDS BEING REQUESTED:**

Medical Records Dates From/To: \_\_\_\_\_  Radiology Reports  Billing Records  
 LMT Records & Billing  Other \_\_\_\_\_

**PURPOSE OF THE DISCLOSURE OF INFORMATION:**

Self  Continuing care  Insurance claim  Other \_\_\_\_\_

An authorization to disclose PHI (Protected Health Information) is voluntary. Treatment, payment or eligibility for benefits will not be affected if you do not sign this authorization. Re-disclosure of a patient's PHI is prohibited without the specific written authorization of that person or as otherwise permitted by state or federal law. Information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by state or federal law. This authorization pertains to the dates specified on this authorization. Unless you revoke this authorization earlier, it will expire 12 months from the date signed. You may revoke this authorization at any time by sending a written notice to the custodian of records.

Signature \_\_\_\_\_ Date: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_

FOR OFFICE USE ONLY	
Employee who reviewed/completed form with patient:	_____
Date received: _____	Date completed: _____ Emp initials: _____
Comments:	_____
Records picked up by: _____	Date: _____