PHI release- Matthew W. Ryan DC PC dba Stewart Clinic of Winder

Name: ____________________________ Account #: _______________________
Address: _________________________ DOB: ____________________________

I hereby request and authorize:
Matthew W. Ryan, DC

PHI request for copies of:
_____Dr. Electronic Notes or Exam notes for Dates of Service______________________
_____X-ray Report for Date of Service:_______________ _____X-ray Films on CD
_____Other, specify: __________________________

How I wish for these copies to be sent to me:
______ Email to _________________________ Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed. (No Charge).
_____ CD ____Mailed (Charge for Postage) ____ Pick up
_____ Paper Copy (This will have a charge of $6.50) ____Pick up ____ Mailed (additional Postage charge)
_____ Sent to another provider

Provider information:
Name:____
Address:____
Phone:____
Email address:______________________________ See note above regarding security of emails.

This authorization will be effective for six months after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

____Date:______________
Signature of Patient

OR
____Date:______________
Signature of Legal Representative/Relationship

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

Office Use: This request was reviewed and approved _____________________
Date______________
______This information was reviewed and not approved. See Denial of PHI form