Amberlight Chiropractic & Wellness
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Consent to Release of Information:

- In accordance with Minnesota Statutes § 144.335, I consent to the release by my provider of my health records and medical information about me to physicians, providers, and staff as necessary for treatment, to insurers as necessary to receive payment for services, and to third parties for purposes of reviewing quality of care and for health care operations (so long as the release is in compliance with applicable law), including releases for internal or external audits, research and quality assurance, or licensing/accreditation purposes.

- I give my permission to my provider to communicate information about me to those people involved in my care for the purpose of my treatment as designated in my medical record.

- I give permission for my provider to communicate with me regarding my medical care, such as results of tests/reports through voicemail messages via the phone numbers I have supplied in my medical record.

- In order to assure proper quality and continuity of care, I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, or third party administrators to share my health records and information obtained from my health care provider or any other provider, with my health care provider, other providers from whom I have received services, or any other payer, payer network organization, or third party administrators as needed for payment and health care operations.

I understand this Consent to Release of Information does not expire unless I revoke it or provide a specific expiration date here: _____

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. BY SIGNING BELOW, I CONSENT TO ALL OF THE USES AND DISCLOSURES ABOVE, AND I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES.