

Authorization for the Release of Medical Records

Patient Name: _____ Date of Birth: _____
(also list maiden name/other names used)

I hereby request and authorize:

The Chiropractic Element
3109 W 6th St., Ste. A
Lawrence, KS 66049

_____ To Disclose information to: _____ To Receive Information from:

Provider: _____

Address: _____

City/State/Zip _____ Fax #: _____

Information to be disclosed include copies of:

_____ Entire Record	_____ X-ray Reports
_____ Progress Notes	_____ X-ray Films
_____ Physical Exam forms	_____ Other, specify:
_____ Daily chart notes	_____

Purpose for disclosure:

_____ Treatment, Payment OR _____ Other (Specify) _____

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.

Signature of Patient Date: _____

OR

Signature of Legal Representative/Relationship Date: _____

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.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