Authorization for the Release of Medical Records

Print Name: _____ Date of Birth:_____

(*Include Maiden Name/Aliases)*

I here by request and authorize:

Allendale Chiropractic Clinic
1210 Allendale Road
Pasadena, Texas 77502
Ph: 713-472-4414 Fax: 713-472-3016

☐ **Disclose Information To:** ☐ **Receive Information From:**

Provider: _____

Address: _____

City/State/Zip:_____

Telephone:_____

Information to be disclosed includes copies of:

☐ Entire Record ☐ X-ray Report ☐ X-ray Films

☐ Progress Notes ☐ Physical Exam Forms ☐ Daily Chart Notes

☐ Other, Specify: _____

Information to be disclosed includes copies of:

☐ Treatment ☐ Payment ☐ 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.

_____ _____

Patient Signature/Signature of Legal Guardian & 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If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.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 guardian/representative.