Authorization for the Release of Medical Records

Patient Name:_____ Date of Birth:_____

I authorize Bountiful Life Chiropractic Center to release my personal health care information to:

_____

Please select 1 of the following:

[ ] Email [ ] Pick-up in clinic [ ] Fax Records [ ] Mail to

*Email/fax#/address information if applicable:

_____

_____

_____

_____

This authorization will remain in effect 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. Types signature serves as valid.

Signature: _____Date:_____

(Signature of Patient or Legal Guardian if under age 18)

Office Use Only:

Initial or N/A: _____ request given to Dr./Intern _____ request completed

_____ patient notified/note on next appt _____ CD/Papers in TBPU folder