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:

____

Information being requested:

☐X-rays ☐SOAP Notes ☐Both ☐Other

Specifics: ____

Via the following method (Please select 1):

☐Email to:____

☐Pick-up in clinic

☐Mail to:____

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:

____ request given to Dr./Intern ____ request completed ____ patient notified/note on next appt

____ CD/Papers in TBPU folder Notes: ____