Bountiful Life
CHIROPRACTIC CENTER

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:_____

**Selection of this option will incur a $13 mailing fee.*

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: _____