Records Release Authorization

Patient Name _____
Address _____
City, State and Zip Code _____ Phone Number _____
Date of Birth _____ Email _____

Records Released From:
Name of Person or Facility _____
Practice Address | Street Number _____
City, State and Zip Code _____ Phone Number _____
Email _____ Fax _____

Records Released To:
Name of Person or Facility _____
Practice Address | Street Number _____
City, State and Zip Code _____ Phone Number _____
Email _____ Fax _____

Please Select all the specific documents to your request:

- ☐ Stentor
- ☐ X-Ray Image
- ☐ X-Ray Report
- ☐ CBCT Report
- ☐ CBCT Image
- ☐ Chart Notes
- ☐ Evaluation/Recommendations
- ☐ Progress Report
- ☐ Other

Please select the purpose of your request:

- ☐ Continued Patient Care
- ☐ Personal
- ☐ New Chiropractic
- ☐ Coordination of Care
- ☐ Other

Preference of sending: ☐ Email _____ ☐ Mail _____ ☐ Fax _____

I understand that I have the following rights:

* The information listed above is being released for the stated purpose. Any other is forbidden.
* I receive a copy (Normal fees apply).
* This authorization is voluntary and I may refuse to sign authorization form. Refusal to sign will not affect your ability to obtain treatment by Clear Chiropractic.
* This authorization is valid for 90 days. I understand that I may revoke authrorization at any time. Your revocation will not apply to release we have already made in response to this authorization.
* I may receive a copy of this Authrorization if requested.
* I understand that once the information listed above has been disclosed: It may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information.
* I have read and understand this authroization and authrorize the use and/or disclosure of health information as discribed in this authorization.
* Records release turn around time is two weeks from request time.

_____
Signature of patient or surrogate decision maker Date

_____
Print name of surrogate decision maker and relationship to patient

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