Chiropractic Records Release Form

I authorize the release of my chiropractic medical records as described below.

Patient Name:

Date of Birth:

Phone Number:

Address:

Name of Facility/Doctor (releasing records):

Phone Number:

Address:

Release records to (Name/Clinic/Provider):

Phone Number:

Address:

Records to be released:

Date(s) of Service:

Purpose of Disclosure:

I understand that this authorization will remain in effect until the following date/event or revocation by me in writing.

Expiration Date/Event:

Signature:

Date:

If signed by a representative, state authority/relationship: