Authorization for the Release of Medical Records

Patient Name:_____Date of Birth:_____
(List maiden name/other names used)

I hereby request and authorize:
Spine Worx Chiropractic & Decompression
6200 Denton Highway
Watauga, TX 76148
Phone: 817-849-2394 Fax: 817-849-2394

___To Disclose/Release information to _____
___To Receive Information from and do by hold harmless anyone from such actions.

Patient: _____

Address: _____

City/State/Zip_____

Information to be disclosed include copies of:

_____Entire Record	_____X-ray Reports
_____Progress Notes	_____X-ray Films
_____Physical Exam forms	_____Other, specify:
_____Daily chart notes	

Purpose for disclosure:
_____ Treatment _____ Payment _____ Other (Specify)

This authorization will be effective for six months after the date signed, 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.

_____Date:_____
Signature of Patient

_____Date:_____
Signature of Legal Representative/Relationship
If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.
Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.