RELEASE OF PATIENT RECORDS AUTHORIZATION

PATIENT'S FULL NAME ________________ DATE OF BIRTH ________________ SOCIAL SECURITY # ________________

I hereby authorize **Anderson County Family Chiropractic, LLC** to release a copy of my patient records and/or x-rays containing protected health information to:

Physician/Facility: ________________
Address: ________________
City/State/Zip: ________________
Phone: ________________
Fax: ________________

Reason for Release: ________________

This authorization is given pursuant to Tennessee Statutes and HIPAA regulations. I authorize that any third party to whom records are disclosed should not be further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives.

________________ ________________
Patient's or Patient's Legal Representative's Signature Date Signed

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Witness

Specific description of information to be disclosed:

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