Corsentino Chiropractic

Authorization for the Release of Medical Records

Patient Name: _____
(also list maiden name/other names used)

Date of Birth: _____

I hereby request and authorize:

Corsentino Chiropractic
3501 Montlimar Plaza Drive
Mobile, AL 36609
Phone: (251) 445-2295
Fax: (251) 445-2299

To Receive Information from:

Provider/Facility: _____

Address: _____

City/State/Zip_____

Information to be disclosed include copies of:

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

Purpose for disclosure:

_____ Treatment, Payment OR
_____ Other (Specify)_____

This authorization will be effective for one year 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.

This consent and authorization may include, but is not limited to, the release of medical, alcohol, and/or drug abuse treatment, psychological, psychiatric, sexually transmitted diseases, and HIV/AIDS information.

_____Date: _____
Signature of Patient

OR

_____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If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.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.