SALUS
CHIROPRACTIC

Record Release

Patient Name: _____ Date of birth: _____ Date: _____

I HEREBY REQUEST AND AUTHORIZE:

Salus Chiropractic
12920 West Parmer Lane, Suite 109
Cedar Park, TX 78613

☐ To disclose information to: ☐ To receive information from:

Provider: _____

Address: _____

City/State/Zip: _____

INFORMATION TO BE DISCLOSED INCLUDE COPIES OF:

☐ Entire Record ☐ X-ray Reports ☐ Progress Notes ☐ X-ray Films
☐ Progress Notes ☐ X-ray Films ☐ Physical Exam forms ☐ Daily chart notes
☐ Other (specify): _____

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.

_____

SIGNATURE **PRINT NAME** **DATE**

or

_____

SIGNATURE OF LEGAL REPRESENTATIVE / RELATIONSHIP **DATE**

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.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