Waccamaw
Chiropractic & Wellness Center

Dr. John B. Evans — Dr. Jeff A. Evans

Medical Records Request

Patient: _____ Date of Request:_____

DOB: _____ Phone: _____

Patient Address: _____

This authorization will expire in one year from the date of signature unless an alternate is requested and noted herewith: Expiration Date: _____

I hereby authorize (name of previous medical facilities/physicians and telephone/fax)

_____

_____

_____

To use and/or disclose to **Waccamaw Chiropractic & Wellness Center**

Description of information to be disclosed:

_____ X-Ray (CD or FILM) + Report _____ MRI (CD or FILM) + Report _____ Other Reports

_____ Other, if so please specify dates as well as visits, tests, labs, etc.

_____

I understand that:

1. I may refuse to sign this authorization and that doing so is strictly voluntary.
2. I may revoke this authorization at any time in writing, but if I do not it will not have any effect on any actions prior to relieving the revocation.
3. If the requestor or receiver is not a health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.

I have read the above and authorize the disclosure of the protected health information stated.

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____

658 Wachesaw Rd., Murrells Inlet, SC 29576
Phone (843) 357-9617 Fax (843) 357-9639
www.waccamawchiropractic.com