Waccamaw
Chiropractic & Wellness Center

Full Name: _____ Date of Birth: _____

This will authorize Waccamaw Chiropractic and Wellness Center to disclose my protected health information, as described to

_____

Please choose one of the options below:

Records will be picked up by: _____ Relationship: _____

Pick up date and time:_____

Address will be mailed: _____

_____

___ Complete copy of medical record Films ___ Disks ___

NOTE: Films must be returned to the office

___ Other: Please specify _____

Dates of care included _____ to _____

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that this authorization may be revoked in writing by me and delivered to Waccamaw Chiropractic and Wellness Center at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been take in reliance on an authorization I have signed.

I understand that information used to disclose pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be federal or state law protecting its confidentiality.

Signature of Patient or Representative: _____ Date: _____

Office use only: File Number: _____

Witness:_____

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