Authorization for the Release of Healthcare Records to Family Chiropractic

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

**I hereby request and authorize:**

Provider:_____
Address:_____
City/State/Zip_____
Phone Number _____

___**X**___**To Disclose information to:**

**Family Chiropractic Center Fayetteville**
**114 South College Ave, Suite A**
**Fayetteville Arkansas 72701**
**479-442-0676**
**Fax 479-442-8066**

**Information to be disclosed include copies of**:

_____Entire Record including X-rays and Images
_____Progress Notes
_____X-rays
_____Other: _____
_____
_____

**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.

_____Date:_____
Signature of Patient

OR

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

_____/_____Date:_____
Signature of Legal Representative/Relationship

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.