Authorization for Release of Medical Information

Patient:
Name:____ Home Phone:__________________________
Previous name under which chart may be listed:____

Address:____ Day Phone:____________________________

City:____ State:_______________ Zip:___________________

Social Security#_____________________________ Date of Birth:___________________ Age:__________

Treating Doctor's Name:____

Health Care Provider:
Who has information you would like released? Please fill out completely.

Requested By:
Advanced Chiropractic and Wellness, PC
2108 Taylor Avenue, Suite 100
Norfolk, NE 68701
Phone: (402) 371-9000
Fax: (402) 371-9233

Information to be released:
Please select (x) all choices that apply.
_______ Complete X-ray films (including written results of MRI, CT, etc.)
_______ Complete Medical Records (including Lab and X-Ray reports, Patient Education Information, etc.)
_______ Other (Specify)

Reason for Release:
____Continuing Care ____Insurance Change ____Second Opinion ____ Move
____Disability ____Legal Other___________________________

Disclosure Statements:

I understand that this authorization will be in effect for 12 months unless cancelled by me in writing. The cancellation will take effect when the provider receives my notice in writing. I understand that signing this authorization is voluntary. I understand that once information is disclosed by Advanced Chiropractic And Wellness, PC that the disclosed documents may no longer be protected by privacy laws.

Authorization:

I authorize the above provider to release the information marked above to the requestor:

Patient Signature:____Date:___________________

If other than patient, state relationship and reason patient cannot sign.