Authorization for the Release of Medical Records

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

I hereby request and authorize:

Pangemanan Chiropractic
1004 Dewey Dr, Lawrenceburg KY 40342.
Phone 502-839-7171

☐ **To Disclose information to:** ☐ **To Receive Information from:**

Provider:_____

Address:_____

City/State/Zip_____

Information to be disclosed include copies of:

_____Entire Record
_____Progress Notes
_____Physical Exam forms
_____Daily chart notes
_____X-ray Reports
_____X-ray Films
_____Other, specify:
_____

Purpose for disclosure:

_____ Treatment, Payment OR _____ 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.

_____Date:_____
Signature of Patient

OR

_____Date:_____
Signature of Legal Representative/Relationship

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

A $25 copying fee is assessed when paper records are requested and must be paid prior to release of records.

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.