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
509 N 13th St.
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.