RELEASE OF RECORDS

Date: ______/_______/________

Patient Name: _____________________Date of Birth: ____/_____/______

I request and authorize Kelly Chiropractic and Rehabilitation, LLC to release my chiropractic records to the organization, agency, or individuals named below.

I certify that this request has been made voluntary and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Re-disclosure of my medical records by those receiving the above authorized information may not be accomplished without further written consent. Without my expressed revocation, this consent will automatically expire upon satisfaction of the need for disclosure, or, no later than thirty (30) from the date of this document.

Please release my records to:

Primary Care Physician____

Other Physicians: ____

Attorney:____

Myself/Other: ____

____

(*Signature of patient or person authorized to sign for patient)*

____

(*Relationship to patient of person authorized to consent)*

I decline your offer to send records to any of the above and will advise you in writing if I wish to do so in the future.

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(Signature of patient or person authorized to sign for patient)