Authorization for the Release of Medical Records

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

I hereby request and authorize:

Moore Chiropractic Clinic
Dr. Debbie Moore or Dr. Candice Polk
6682 Hwy 11 N Suite 103
Carriere, MS 39426
Phone: (601) 749-4939
Fax: (601) 749-3818

Mail to: Moore Chiropractic Clinic
PO Box 326
Picayune, MS 39466
Fax: (601) 749-3818

Email: PicayuneMCC@aol.com

XXX To Disclose information to: **_XXX_ To Receive Information from:**

Business Name:_____

Attention:_____

Address:_____

City, State Zip_____

Phone Number _____ Fax Number _____

Claim Number/File Number _____

Information to be disclosed include copies of:

_____Entire Record
_____Progress Notes
_____Physical Exam forms
_____Daily chart notes
_____All Reports (X-Ray, CT, MRI, etc)
_____X-ray, DR, CT (Films/Disc/JPEG)(Mailed or emailed)
_____Other, specify:
_____

Purpose for disclosure:

_**XXX**_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.

X_____Date:_____
Signature of Patient or Responsible Adult

_____
Printed Name and Relationship of Responsible Adult

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

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.