627 N Main St. Ste 2
Waynesville, NC 28786

RECORDS REQUEST

Patient Name:

_____ _____ _____
LAST FIRST MI

Date of Birth: _____/_____/_____

I authorize release from:

_____

_____

_____

_____

To release information to:

Family Circle Chiropractic
627 N Main St. Ste. 2
Waynesville, NC, 28786

PURPOSE OF DISCLOSURE

☐ Further Medical Care
☐ Legal
☐ Disability
☐ For Personal Use
☐ Payment of Claim
☐ Other (specify): _____

INFORMATION TO BE RELEASED: Between Dates of: _____ and _____

☐ Health & Physical Exam/Initial Evaluation
☐ Progress Notes
☐ Lab Reports
☐ Other (Specify content/dates): _____
☐ X-Ray Report
☐ X-Rays
☐ Ultrasound Report
☐ Dexa Report

ACKNOWLEDGEMENT OF UNDERSTANDING:

- **I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.**
- **I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.**
- **I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.**
- **I understand I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.**

_____ _____ _____ _____
Signature of patient, parent of minor, or personal representative | Relationship | Date | Phone

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION