Authorization for the Release of Medical Records

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

I hereby request and authorize:

Greco Family Chiropractic
144 York Road
Warminster, PA 18974

_____To Disclose information to: **_____To Receive Information from:**

Provider:_____

Address:_____

City/State/Zip_____

Information to be disclosed include copies of:

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

Purpose for disclosure:

_____ Treatment, Payment OR _____ Other (Specify)_____

This authorization will be effective until 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If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

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.