Authorization to Release Medical Records

Name of Patient: _____ Date(s) of Service: _____
Date of Birth: _____ Social Security Number: _____

I, understand, authorize the release of, or request access to the information specified below from the medical record)s) of the above named patient.

Patient Information is needed for:

- ☐ Continuing Medical Care
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Military
- ☐ Personal Use
- ☐ School
- ☐ Social Security/Disability
- ☐ Other: _____

Information to be released or accessed:

- ☐ History & Physical
- ☐ Operative Reports
- ☐ Lab/Path Reports
- ☐ Consultation Report
- ☐ Discharge/Death Summary
- ☐ X-Ray Reports/Images
- ☐ Emergency Room Records
- ☐ Other: _____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

_____

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) **Phone Number**

_____

Address (Street, City, State, and ZIP)

FROM:

Iselborn Chiropractic and Physical Therapy
3355 Hendricks Avenue
Jacksonville, FL 32207
PHN: (904)731-3000; FX (904)398-5090

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, genetic testing or communicable disease, including HIV and AIDS. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Signature: _____ **Date:** _____
Patient or Legally Authorized Representative

_____
Printed Name of Patient or Legally Authorized Representative

_____
Relationship to Patient