Patriot Chiropractic Center

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Date: _____

Patient Name: _____
Date of Birth: _____

This is a signed release by the patient that Patriot Chiropractic Center has authorization to release copies of my medical file including case history, treatment plan, x-rays /reports, progress notes, or any information obtained as a result of your consultation, examination and related treatment.

This release does apply in connection with HIPPA and does follow the regulations set forth by HIPPA. Once the copies are released to the authorized parties Patriot Chiropractic Center is no longer responsible for those copies of your medical file.

Patient Signature: _____

Address: _____
_____

Phone: _____
Email: _____

I HERBY AUTHORIZE PATRIOT CHIROPRACTIC CENTER TO RELEASE COPIES OF MY MEDICAL FILE TO:

Name: _____

Address: _____
_____

Phone: _____
Fax: _____