

Authorization for the Release of Medical Records

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

I hereby request and authorize:

Moore Chiropractic Clinic
Dr. Debbie Moore, DC, LAc
6682 Hwy 11 N Suite 103
Carriere, MS 39426
(601) 749-4939 (O) (601) 749-3805 (F)

To Disclose information to: To Receive Information from:

Provider: _____

Address: _____

City/State/Zip _____

Information to be disclosed include copies of:

<input type="checkbox"/> Entire Record	<input type="checkbox"/> All Reports(X-ray,MRI,CT,Bone Scan,etc.)
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> X-ray Films
<input type="checkbox"/> Physical Exam forms	<input type="checkbox"/> All Lab Reports
<input type="checkbox"/> Daily chart notes	<input type="checkbox"/> Other, specify: _____

Purpose for disclosure:

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

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If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.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