Crabtree Chiropractic Center

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REQUEST My Medical Records BE SENT

Patient FULL LEGAL Name (please print): _____

Patient Date of Birth: _____/_____/_____

☐ *I am requesting that Crabtree Chiropractic Center release my protected health information as specified below to:*

Physician/Office Name: _____

Address: _____

Phone#: _____ Fax#: _____

Please indicate the specific documents that apply to your request:
□ X-rays
□ Office Notes
□ My record from Dates of Service _____/_____/_____ to _____/_____/_____
□ My record in its entirety

This request is being made for:
□ Processing Insurance Claims (Auto or Health)
□ Second Opinion
□ My personal record
□ Other _____

By signing this form, I do hereby authorized Crabtree Chiropractic Center to release my private healthcare information as outlined above. I understand that there may be a cost for such information and that I will be informed of such charge and held accountable for the charge before any records will be released.

_____ _____ _____
Printed Full Legal Name **Patient Signature** **Date**