Crabtree Chiropractic Center P.A.

Dr. Marc Burr
Dr. Zachary Scott
Dr. Thomas Andersen
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www.crabtreechiropractic.com

Medical Records Release Form

Patient Name:_____ **Patient Date of Birth**:_____

☐ I am requesting that Crabtree Chiropractic Center release my protected health information to:

AND/OR

☐ I am requesting the below entity to release my protected health care information to Crabtree Chiropractic Center:

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**

S: Forms/records/medical records release

Therapeutic Massage

Debbie Beard *919-696-7400*

Mary Seitz Bridges *919-539-6798*

By Appointment only

The Garden at CRABTREE CHIROPRACTIC