ANDOVER
SPINE & HEALTH
A Chiropractic Wellness Center

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: ____

Patient's Date of Birth: ___________________________________

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to the entity listed below.

Andover Spine and Health Center
105 S. Andover Road, Suite E
Andover, KS 67002
Fax: (316)733-9557

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it.

Signature: ____ Date: ____________________

I DO NOT WISH TO AUTHORIZE RELEASE OF INFORMATION.

Signature: ____ Date:_____________________