ANDOVER
spine & health
chiropractic wellness

RECORDS RELEASE

105 S. Andover Road, Suite E
Andover, KS 67002
Phone: (316) 733-9555 Fax: 733-9557
Email: info@andoverspine.com

Patient Name:_____ Date of Birth: _____

Address:_____

REQUESTED RECORDS

☐ To be released to: ☐ To be received from:

Name of Doctor or Facility: _____

Practice Address: _____

Phone: _____ Fax: _____

Please select all the records that apply to your request:

☐ Clinic Notes ☐ Radiology Reports ☐ Medication Record ☐ Entire Record

☐ History & Physical ☐ Lab Reports ☐ Emergency Room ☐ Pathology Reports

☐ Other: _____

Please select the reason for your request:

☐ Continued Patient Care ☐ Attorney / Legal ☐ Insurance ☐ Social Service / Disability

☐ Worker's Compensation ☐ Personal ☐ Other: _____

CONSENT

I do hereby consent and authorize Andover Spine and Health Center to release or receive copies of my medical records.
If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.
A copy of this authorization is as valid as the original.

Signature: _____ **Date:** _____

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.