We've got your back.

Celine H. Lemieux Chiropractic Physician

AUTHORIZATION TO RELEASE MEDICAL RECORDS

TO: The Custodian of Records for:

Dr. Celine H. Lemieux
Chiropractic Clinic of Gretna, Inc.

Please RELEASE my medical formation

(Please Print)

_____	_____	_____/_____/_____
Your Full Name	**Last 4 Digits SSN**	**Date of Birth**

_____	_____	_____	_____
Address	**City**	**State**	**Zip**

_____	_____
Phone	**E-Mail**

Purpose of Records: (Check One)

Personal Use_____Primary Care Physician_____Transferring care_____For Insurance/Attorney_____

Please note*Please allow 10 business days for your request to be processed. There will be a $25.00 fee for the release of your most current records including your most recent X-Ray study.**

I understand that the authorization for disclosure or records as detailed above, unless specifically limited by me in writing, will extend to all aspects of the treatment provided to you here at this office. Chiropractic Clink is hereby released from all legal responsibility for the release of the above disclosure of information. I have the right to withdraw this authorization at any time and such revocation must be in writing.

_____	_____
Signature	**Date**

_____
Print Name

_____
Parent's Signature if Minor