ATLAS FAMILY CHIROPRACTIC, LLC, P.A.

Release of Medical Records

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

I hereby request and authorize Atlas Family Chiropractic, LLC, P.A. to furnish, discuss with, and release to _____ the following protected health information about me:

_____ A complete copy of my chiropractic record including records of office visits, notes, treatments, diagnostic tests, x-rays, prognosis, and treatment plans

_____ My records pertaining to dates of service from: _____ to _____

_____ Specifically _____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:

YES, DISCLOSE THIS INFORMATION: _____

NO, DO NOT DISCLOSE THIS INFORMATION: _____

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying Atlas Family Chiropractic in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

The intended purpose/use of the information is for _____

This authorization expires on _____, 20___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____

Signature: _____ Date: _____

Printed Name of Parent/Guardian (if applicable): _____ Relationship:_____

This form must be faxed to Atlas Family Chiropractic at 207-353-4074.

There may be a fee for records in accordance with Maine law.