AUTHORIZATION FOR RELEASE OF RECORDS

FINNIGAN CHIROPRACTIC CENTER
Dr. Aaron Odd, D.C. A.O.
5191 Corporate Center CT SE
Lacey, WA 98503
Office: (360) 459-7800
Fax: (360) 459-1216

DATE _____

I, _____, am a patient who received care and treatment at your facility and hereby authorize and request you to release the following records:

- ☐ A full and complete copy of my medical records. Date Range _____
- ☐ Radiology films, MRIs or CT scans. X-rays performed at Finnigan Clinic (**CD only**).
- ☐ Billing records.
- ☐ Other: _____

Requested format:

- ☐ Electronically in accordance with the HI-TECH Act ($0-$10.00).
  - Fax number: _____
  - Secure email: _____
- ☐ Copy Xrays to CD and pickup ($7.50).
- ☐ Copy Xrays to CD and mail (Cost $22.00).
- ☐ Paper copies. (Subject to clerical and copy fees).
  - Mail records to: _____
  - _____
  - _____

Requests will be processed within 30 days, as required by law. If a fee is owed, we will contact you for payment before records are prepared and sent.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____

Parent/Guardian Name (if applicable): _____

Parent/Guardian Signature: _____