

Fairbanks Chiropractic Clinic

1118 2<sup>nd</sup> Avenue

Fairbanks, Alaska 99701

Phone: 456-6213 Fax: 452-5925

**RELEASE OF MEDICAL INFORMATION**

**I AUTHORIZE THE USE/DISCLOSURE OF HEALTH INFORMATION ABOUT ME  
AS DESCRIBED BELOW**

**Patient Name:** \_\_\_\_\_

**Patient's Date of Birth:** \_\_\_\_\_

**Patient's SSN:** \_\_\_\_\_

A. Person(s) or Organization(s) authorized to provide the information:

B. Information requested:

\_\_\_\_ Progress Notes

\_\_\_\_ X-Ray Reports/Films

\_\_\_\_ Other(List)

\_\_\_\_ Lab Reports

\_\_\_\_ Imaging

\*Ct/Scan

\_\_\_\_ Hospital Reports

\*MRI

\_\_\_\_ Surgical Reports

\*US

\_\_\_\_ Consultation

1. I understand that this authorization will expire 6 months from date signed.
2. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Fairbanks Chiropractic Clinic in writing.
3. I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment of my eligibility for benefits (if applicable)
4. I may inspect or copy any information used or disclosed under this agreement.

Patient Signature/Guardian X \_\_\_\_\_

Date \_\_\_\_\_