AUTHORIZATION FOR RELEASE OF RECORDS

130 East Bardin Road, Suite 144
Arlington, Texas 76018-1030

Phone: (817) 419-6681
Fax: (817) 465-3580

E-mail: ChiroNeuro@Yahoo.com
www.ChiroNeurology.com

Patient Name: _____ Date of Birth: _____ SS# _____

I authorize the release of my protected health information as outlined below. See 45 CFR §164.508 (c)(1)(i)

- ☐ All Records
- ☐ X-rays and reports
- ☐ Billing Records
- ☐ Other: _____
- ☐ History and Physical
- ☐ Laboratory Reports
- ☐ Consent Forms

From: Name _____
Organization: _____
Address: _____
_____
Phone: _____
Fax: _____

To: Arlington Chiropractic Neurology Center
Michael Combs, DC, DACNB, FACFN
130 E. Bardin Road, Suite 144
Arlington, TX 76018
Tel: 817-419-6681 Fax 817-465-3580

See 45 CFR §164.508 (c)(1)(iii)

Reason for release: See 45 CFR §164.508 (c)(1)(iv)

- ☐ Supplement patient's history file
- ☐ Transferring doctors
- ☐ At the request of the patient

Authorization for release is:

- ☐ Self
- ☐ Guardian
- ☐ Power of Attorney

I have read this authorization in its entirety and understand the following: See *45* CFR §l64.508(c)(2)(i-iii)

a. I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law.
b. I have a right to revoke this authorization in writing at any time, except to the extent information has already been released in reliance upon this authorization.
c. The information disclosed in response to this authorization may be re-disclosed to other parties and no longer protected.
d. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
e. I may be charged a fee for copies of these medical records according to State and Federal Laws.
f. I agree that a facsimile or photocopy of this authorization is as valid as the original.

Signature: _____ Date: _____

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