Medical Records Release Authorization

Requester Name:_____ Request Date: _____

Patient Name: _____Date of Birth:_____
(also list maiden name/other names used)

I hereby request and authorize: Katy Lifestyle Chiropractic
25807 Westheimer Parkway, Ste 270, Katy, TX 77494
Phone: 281-347-4444 Fax: 281-347-4445

_____To Disclose information to: _____ To Receive Information from:

Name or Provider:_____

Address:_____

City/State/Zip_____

Phone: _____Fax: _____ eMail:_____

Requested information: (Please check)

_____Daily chart notes for dates: _____ to _____

_____X-Ray Images on Computer Disk

_____Other information, specify: _____

Reason for request: __Treatment __ Moving __Other **(explain)**_____

(1) Although we usually fulfill medical records requests within 5 business days, it may take up to 15 business days. (2)A fee may be assessed to fulfill this request. Ask for more details (3) This authorization will be effective for six months after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. (4)A copy of this authorization is as valid as the original. (5) If email delivery is requested, signatory acknowledges and authorizes records be sent via non-secured email.

_____Date:_____
Signature of Patient

_____Date:_____
OR Signature of Legal Representative

_____
Printed name of Legal Representative and relationship to patient

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.
Notice to recipient of information: *This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.*

FOR OFFICE USE ONLY R2019/07/29	Req Rec'vd Date & CA Init	Fulfillment Date	Approved by LC,DC	Delivery Method	CA Initials / CT. Notes Entered