



Authorization for the Release of Medical Records

Patient Name: _____

Date of Birth: ___/___/___

I hereby request and authorize: Thrive Chiropractic and Wellness 1190 E Bridge St, Brighton, CO 80601

_____ To Disclose information to:

_____ To Receive Information from:

Provider: _____

Address: _____

City/State/Zip: _____

Information to be disclosed include copies of:

_____ Entire Record _____ X-ray Reports _____ Progress Notes _____ X-ray Films _____ Physical Exam forms

Daily chart notes _____ MRI REPORT _____ Other, specify: _____

Purpose for disclosure:

_____ Treatment _____ Payment OR _____ Other (Specify) _____

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. A copy of this authorization is as valid as the original.

Signature of Patient

Date

Signature of Legal Representative/Relationship

Date

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.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.