AUTHORIZATION FOR MEDICAL RECORDS

Patient Name: ______________________________Date of Birth: ________________________

Address: ____

City/State/Zipcode: ____

Home Phone: ______________________________Cell Phone: __________________________

REED CHIROPRACTIC
250 W. BASELINE ROAD SUITE 107
TEMPE, AZ 85283
PHONE: (480) 785-1355 FAX: (480) 222-0453

______ To Release Information To: **_____ To Receive Information From:**

Name: ____
Address: ____
City/State/Zip:____
Phone: ___________________________________Fax: _______________________________

Information to be disclosed include copies of:
____ Complete Medical Records (History, Exam, Progress notes, Consultation etc.)
____ All X-Ray Reports, Films, MRI's CT Scans
____ Any test results, Lab reports, Pathology reports
____ Medical Records related to a specific injury or illness.
____ Other/Special Instructions: ____

Outgoing X-Rays

I hereby authorize the release of my Records / X-Rays. Also, I release the doctor of all responsibility with regard to the x-ray films that are being released.These x-ray films represent a part of the patient's permanent file. They are to be returned by mail to this office. This loan is made with the express understanding that they will NOT be returned through a third party or delivered by the patient or relative. Thank you for your cooperation.

Enclosed please find the following x-ray films:

8 x 10 ________ 10 x 12 ________ 14 x 17 ________ 14 x 36 ________

Signature: ____ Date:________________