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Huntersville, NC 28078
704-727-0784 • 888-758-9829 (FAX)
info@AceFamilyChiropractic.com

Authorization For Release of Information

I authorize Ace Family Chiropractic to disclose health information regarding the below referenced patient. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

I understand that unless I revoke the authorization earlier, this authorization will automatically expire six (6) months after the date this authorization is signed.

Patient Name: _____ DOB: ___/___/___ SSN: _____
Address: _____

Please send my ☐medical records ☐ x-rays in your possession concerning my illness and or treatment starting with date _____ to _____ to the individual or organization below.

I would like the requested information be ☐mailed ☐faxed to:

_____
Individual or Organization

_____
Address

_____
City, State Zip

_____
Phone

_____
Fax

I certify that I am:
____ the patient
____ the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. I am the patient's (relationship) _____.

_____ _____ _____
Signature (Patient / Guardian) Print Name Date