Authorization for the Release of Medical Records

Patient Name:_______________________________
(Also list maiden name/other names used)
Date of Birth:_____________________

I hereby request and authorize: **Full Circle Chiropractic**
13435 University Avenue, Ste. 150
Clive, IA 50325
Phone: 515.226.2155 * Fax: 515.226.7990

_______**To Disclose information to:** (and/or) _______**To Receive Information from:**

Name/Provider: _________________Self_____________________________
Address: ____
City/State/Zip: ____
Phone: ________________________ Fax: _____________________________

Information to be disclosed includes copies of:

_____Entire Record
_____Progress Notes
_____Physical Exam forms
_____Daily chart notes
_____X-ray Reports
_____X-ray Films
_____MRI / Reports
_____Other, specify: _____________________________

Purpose for disclosure:
_____ Treatment, Payment OR _____ Other (Specify)____________________________________

Unless otherwise specified, all records are distributed by CD. If requesting information be transmitted through electronic communication, I understand the risks associated with unencrypted email use and waive Full Circle Wellness Center and its employees of any liability if my personal electronic communications are accessed by an unauthorized individual.

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.

____Date: ______________
Signature of Patient
OR
____Date: ______________
Signature of Legal Representative/Relationship
(If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.)

Under federal law, medical provider has 30 days to provide records.
No guarantee is made to send records per a requested expedited time frame by requestor.

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.

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