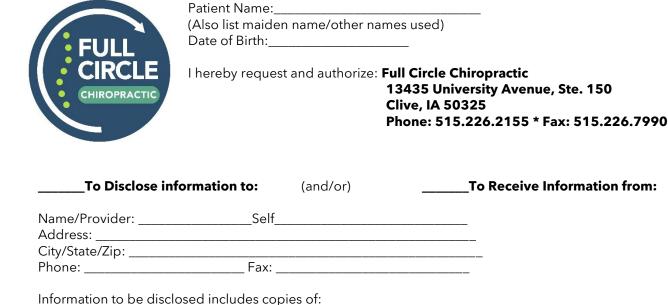
Authorization for the Release of Medical Records



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.

_____ Treatment, Payment OR _____ Other (Specify)_____

X-ray Reports

MRI / Reports

Other, specify: _____

X-ray Films

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(If signing for a minor patient, I hereby state that my parental rights	have not been revoked by a court of law.)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

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.

No guarantee is made to send records per a requested expedited time frame by requestor.

Entire Record

Progress Notes

___Daily chart notes

Purpose for disclosure:

_Physical Exam forms