Carey Chiropractic **Dr. Paul F. Carey D.C.**

Authorization for the Release of Medical Records

Patient Name: _____ Date of Birth: _____
(also list maiden name/any other names used)

I hereby request and authorize:

Carey Chiropractic
147 Columbus Road
Athens, OH 45701

_____ To Disclose Information to:
_____ To Receive Information from:

Provider: _____

Address: _____

City/State/Zip: _____

Information to be disclosed include copies of:

_____ Entire Record
_____ Progress Notes
_____ Physical Exam Forms
_____ Daily Chart Notes
_____ X-ray reports
_____ X-ray Films
_____ Other, specify: _____

Purpose for disclosure:

_____ Treatment, Payment OR _____ Other, specify: _____

This authorization will be effective for six months after the date signed, unless canceled 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