SPRING CHIROPRACTIC

AUTHORIZATION FOR
RELEASE OF PATIENT RECORDS

I hereby authorize Spring Chiropractic to release a copy of my patient records and/or x-rays containing protected health information to See checked below . This information is given pursuant to Florida Statute 456.057 and HIPAA regulations. I also understand Florida Statute 456.057(10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representative(s).

_____ _____
Patient Signature or Legal Representative's Signature Date Signed

_____
Patient's Date of Birth

Check Boxes Below That Apply:

- □ Health Insurance Company
- □ Auto Insurance Company
- □ Patient Retained Attorney
- □ Diagnostic Imaging Center
- □ Diagnostic Testing Center
- □ Referred Physician
- □ Referred Therapist
- □ Other _____

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