SCHILSKY CHIROPRACTIC CENTER

312 DOLPHIN DRIVE, JACKSONVILLE, NC 28546
OFFICE 910-347-4033 FAX 910-347-0854

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

ACCOUNT#: _____DATE: _____ CA INITIALS COLLECTED FORM: _____ CA COMPLT RECORD: _____

PATIENT'S NAME:_____PATIENT'S MAIDEN NAME/OTHER:_____

DOB: _____ADDRESS: _____ CITY/STATE/ZIP: _____

PHONE #: _(_____)_____ EMAIL:_____@_____

HEREBY AUTHORIZES THE RELEASE OF PROTECTED HEALTH INFORMATION AS FOLLOWS:

TO: _____

_____
Mailing Address - City/State/Zip

_(_____)_____ _(_____)_____
Phone Fax

PLEASE SELECT HOW YOU WOULD LIKE THE RECORDS TO BE RECEIVED (SELECT ONE):

___ Emailed to: _____

___ Faxed to: _____

___ Mailed to: _____

___ Pick Up At Schilsky Chiropractic

SELECT ALL THAT APPLY:

____ Full Medical Record with Xray written report *does not include Xray CD
____ Visit Notes and History
____ CD with Xray Images ($25 additional charge)
____ Written Diagnostic Image Report of XRay *does not include XRAY Image CD

FEES FOR MEDICAL RECORDS

****MUST PAY AT THE TIME OF THE REQUEST FOR ALL RECORDS**

$20.00 for up to 20 dates of service
$30.00 over 21 dates of service
$25.00 X-Ray CD
****Minimum payment of $20**

Date Paid:_____

Amount Paid:_____

Form of Payment: _____

CA Initials:_____

SENT VIA: Mail, Fax, Email, or Pickup

Date Sent:_____ CA Initials:_____

By signing this authorization, I understand that I have the right to receive a copy of my records upon written request. This authorization is valid for (1) year from date of signature, unless otherwise revoked in writing. A copy of this authorization gives the same rights and permissions as the original.

Patient or legally authorized individual signature: _____ Date: _____

Printed Name if signed on behalf of the patient: _____

Relationship (parent, legal guardian, personal representative): _____

CONFIRM PICKUP

Patient Signature at pickup_____ Date: _____