Saleeby Chiropractic Centre, P.A.

Stephen M. Saleeby, D.C.
Wayne J. Prickett, D.C.

Medical Release Form

The authorization for use or disclosure of my health information is required by state and federal law.

Patient Name: _____ Date of Birth: _____

I, _____ authorize _____, to disclose my protected medical information to the following parties:

_____
(Name)

_____
(Street Address)

_____
(City) (State) (Zip) (Phone)

This authorization applies to the following information:

□ Medical Records □ Financial/Insurance

□ X-Rays/Reports □ History/Physical Findings

□ Treatment Dates/Services □ Other: _____

I hereby authorize the release of my health information, as described above, as described above, to the above stated company, facility, individual. If not revoked earlier, this authorization shall terminate upon the final resolution of all claims related to the claim number set forth above (if applicable). I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, but giving written notice to the Provider.

Patient Signature: _____ Date: _____

Witness Signature:_____ Date: _____

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