Cy-Fair Chiropractic and Health Care Associates, P.C.
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MEDICAL RECORDS REQUEST

Informed Authorization and Consent for the release of Medical Records

I, _____ , hereby authorize the release of:
(Patient's name)

CHECK ALL THAT APPLY
( ) Entire Medical Records
( ) Test Results
( ) X-Ray disk
( ) MRI Report and/or disk
( ) Other
_____

( ) I, the above stated patient, am requesting and/or picking up my own records.
( ) If I am not available to pick up my own records, I hereby authorize:

_____
(Authorized party's printed name)
( ) I request that my information be delivered by way of: FAX E-MAIL MAIL
(Circle One)

Delivery Method Info: _____

I do expressly and voluntarily authorize the disclosure of the said medical records to the person(s) and/or entity(ies) as stated above. This authorization/consent will remain in effect for the period of one (1) year from the date stated, unless revoked in writing by the person to which it pertains (or his/her parent, legal guardian or legally authorized agent) to the Medical Records Department.

INITIALS REQUIRED

(____) I understand that a fee of $25 may be required before receipt of above requested records/reports/disks.

(____) I understand that Cy-Fair Chiropractic and Healthcare Associates is given thirty days to process my request, and if required, an additional thirty days deadline if I am notified in writing of the extension.

(____) By signing below, I acknowledge and agree to the above conditions.

_____ _____
Patient, Parent, Legal Guardian Date