**RISNER CHIROPRACTIC AND WELLNESS CENTER**

**GENERAL MEDICAL RECORDS RELEASE AUTHORIZATION**

Please complete the following information:

Patient Name:

Address:

Phone:

SSN: Date of Birth: / /

I hereby request and authorize Risner Chiropractic and Wellness Center to release protected health information, including copies of the medical record of the above-named patient to the following person or facility:

Attorney / Insurance Cpmapny /Other

Address Telephone

Information to be released:

 Progress Notes X-ray/Report

 Medical Record Billing Record

 Verbal Communication (My Insurance Company or My Legal Representative)

The information may be disclosed for the following purposes:

 Continuing Care Payment/Insurance

 Legal Purposes Payment/Insurance

 At My Request

By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information.

Signature of Patient (or patient’s personal represtnative) Date

Printed Name of Patient Representative Representative’s Authority to Sign for Patient (i.e parent, guardian, power of attorney for healthcare, executor)

Witness