RELEASE OF PROTECTED HEALTH INFORMATION RECORDS

WHOLE FAMILY CHIROPRACTIC
160 NE Maynard Rd. Suite 204
Cary, NC 27513
Phone: 919-461-3933
Fax: 919-461-3944

Release From: _____
Phone: _____
Fax: _____

Patient Name:_____
D.O.B. _____
Phone: _____

Release The Following Protected Health Information:

I, the undersigned, request and consent to the release of the following Protected Health Information:

X-Rays History Diagnosis Treatment Reports Other_____

Send The Protected Health Information To:

Clinic Name_____
Address_____
_____
Phone_____

Purpose Of Release

- ☐ For the purpose of treatment at the above health care facility
- ☐ Other_____

Patient: _____ _____
Patient or Legal Representative Date

Witness: _____ _____
Privacy Officer Date

The Protected Health Information of the above referenced patient will be used solely for the purpose of treatment, payment, and operations. This facility complies with all applicable federal and state privacy statues.