Authorization for the Release of Medical Records

Patient Name:_____Date of Birth:_____/_____/_____
(also list maiden name/other names used)

I hereby request and authorize:

Coastline Chiropractic and Rehabilitation Center

1536 Fording Island Road, Suite 106

Hilton Head Island, SC 29926

_____To Disclose information to: _____To Receive Information from:

Provider:_____

Address:_____

City/State/Zip_____

Information to be disclosed include copies of:

_____Entire Record
_____Progress Notes
_____Physical Exam forms
_____Daily chart notes
_____X-ray Reports
_____X-ray Films
_____Other, specify:
_____

Purpose for disclosure:

_____ Treatment, Payment OR _____ Other (Specify)_____

This authorization will be effective for six months after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.
I understand that there may be a reasonable medical records copying fee as permissible by South Carolina State Law. I understand the release of my records may take up to 14 days as stated by South Carolina State Law.

_____Date:_____
Signature of Patient

OR
_____Date:_____
Signature of Legal Representative/Relationship
If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.