ADVANTAGE CHIROPRACTIC, PLLC
1003 Oakhurst Dr. Suite 3
Charleston, WV 25314

PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I understand that my family members, friends, and co-workers may ask questions about my medical condition over the telephone or in person. I also understand it is a breech of physician-patient confidentiality for my doctor to discuss my medical information in any way with anyone without my expressed written consent. By signing this form I am designating the parties below with whom I wish Advantage Chiropractic, PLLC to be able to discuss my medical condition.

If I change my mind regarding the release of information to any of the listed people, it is my responsibility to inform Advantage Chiropractic, PLLC in writing of my decision.

In accordance with the above, I _____ (patient's name), hereby authorize Advantage Chiropractic, PLLC to discuss with and release my medical information to the following individuals:

_____ _____

_____ _____

The below individuals are authorized to pick up x-ray films on my behalf.

_____ _____

_____ _____

Furthermore, I understand that if there is any information in my medical record I do not want discussed with or released to the above, I must designate it here by stating what information is to be excluded.

NOTIFY IN CASE OF EMERGENCY _____

_____ _____
Patient Signature Date

_____
Print Name