Record Release

Patient Name : _____
Date of Birth : _____

I HEREBY REQUEST AND AUTHORIZE:
Dr. Terry Hamilton, DC
4519 N Garfield Suite 1
Midland TX 79705
432-685-0777 FAX 432-685-0778

To Disclose Information to:
Name : _____
Address : _____
City/State/Zip : _____
Fax: _____

Information to be disclosed include copies of:
Entire Record
Xray reports

Purpose of Disclosure
Treatment/Information

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.

Signature _____

Printed Name _____

Date _____

Or
Signature of Legal representative / Relationship _____

Date _____

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.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.