

Authorization To Release Medical Records:

PATIENT INFORMATION:

Name (Print) \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

INFORMATION TO BE RELEASED FROM

Name of Facility or provider: \_\_\_\_\_

Address: \_\_\_\_\_

INFORMATION TO BE SENT TO:

Kurtz Chiropractic Center  
3011 Raleigh Road Parkway  
Wilson NC, 27886  
P: (252)234-0000 F: (252)291-3232

INFORMATION TO BE SENT TO:

Name of designated recipient: \_\_\_\_\_

Address \_\_\_\_\_

INFORMATION TO BE RELEASED: (CHECK ONE)

- The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)
- All Medical Records
- Specific Information (please specify): \_\_\_\_\_

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE

- Attorney
- Insurance
- Doctor
- Personal

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

\*EXCLUDE the following information from the records released (please initial)

- Drug/Alcohol abuse/treatment & diagnosis
- Sexually transmitted disease
- HIV/AIDS diagnosis/treatment/testing
- Mental illness or psychiatric

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: \_\_\_\_\_  
(Patient, Guardian, or Authorized representative)

Date: \_\_\_\_\_

Expiration: \_\_\_\_\_