Authorization for the Release of Medical Records

Patient Name: _____ Date of Birth: _____

I hereby request and authorize:

Denver Sports and Family Chiropractic Center
1720 S. Bellaire St, Suite 406
Denver, CO 80222
303.758.1100 phone
303.997.1054 fax

☐ **To Disclose information to:** ☐ **To Receive Information from:**

Name/Provider: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Information to be disclosed include copies of:

☐ Entire Record	☐ X-ray reports
☐ Progress Notes	☐ X-ray films
☐ Physical Exam forms	☐ MRI / Reports
☐ Daily chart notes	☐ 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.

Patient Signature: _____ Date: _____

Note 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.

1720 S. Bellaire St, Suite 406 | Denver, CO 80222 · **O:** 303.758.1100 **F:** 303.997.1054 · **W:** www.DenverSportsChiro.com