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Ankeny, IA 50023

Phone: (515) 965-8280
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patients@labountychiropractic.com

Authorization for the Release of Medical Records

Patient Name:_____ Date of Birth:_____

I authorize LaBounty Family Chiropractic & Dr. _____ to release my personal health care information to:

[ ] Self [ ] Dr/Clinic: _____ [ ] Other: _____

Please select 1 of the following:

[ ] Email to: (digital files-jpeg & pdf) ____ X-rays ____ Adjustments and Exam Notes

Email address: _____

[ ] Pick-up in clinic: ____ X-rays (on CD) ____ Adjustments and Exam Notes

for contact: _____

[ ] Fax Records: ____ Patient File SOAP notes

Attn name & fax #:_____

[ ] Mail to:

Address:_____

City/State:_____ Zip:_____

This authorization will be effective for 1 year 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: _____Date:_____

(Signature of Patient or Legal Guardian if under age 18)

Office Use Only:

Initial or N/A: _____ request given to Dr./Intern _____ request completed

_____ patient notified/note on next appt _____ CD/Papers in TBPU folder