Sitzmann Chiropractic, L.L.C.

224 Feaster Rd. Suite C
Greenville, S.C. 29615
(864) 458-8888
sitzchiro@bellsouth.net

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: ______________________ Date Of Birth: _________

Patient's Address: _____________________ SS#: _________________
____
_____________________ Phone#: _______________

By signing this authorization, I am requesting that a copy of my protected health information be disclosed:

TO: (Required)
____
(Practice Name, Physician, Organization)
____
(Mailing Address)
____
(City, State, Zip Code)
____
(Phone Number)
____
(Fax Number)

FROM:
Sitzmann Chiropractic, L.L.C.
224 Feaster Road Suite C
Greenville, SC 29607
864-458-8888
(Phone #)
864-458-8848
(Fax #)

All identifiable health information about me including progress notes, history and physicals, laboratory reports, consultations, radiological reports, and other pertinent information should be released to the above entity/person. I understand that the records may contain information of a personal and confidential nature and may include reference to infectious diseases, psychiatric care, sexual assault, alcohol abuse or drug abuse. Any limitations to this statement are noted as follows: _____________________________________
____
____

This authorization may be revoked at any time by notifying both of the above parties in writing. Without revocation, this authorization will automatically expire within 60 days of the receipt of this signed authorization.

My signature below indicates that I have read and understand this authorization of Release of Medical Records.

____ __________________
Patient Signature (or Legal Representative) Date