Lakeshore Chiropractic And Sports Rehabilitation **Release Form**

Date of Release	

Patient Name (print)		
Patient Identification	Social Security:	Date of Birth:
Purpose of Request		

Office Requesting Records

Lakeshore Chiropractic and Sports

1302 Bridge St

Charlevoix, Mi 49720

Phone: (231) 237-0665

Fax: (231) 237-0672

Please Send The Following Records / Reports / Films

	All Medical Records (see below restrictions) for the Following Date (s):	
	All Emergency Room Records Dated:	
	X-Ray / MRI/ CT Reports Dated:	
	X-Ray / MRI/ CT Films Dated:	
	Other:	Dated:

Office Holding Records:

Doctor's Name:	
Address:	
Telephone:	
Fax:	

I, (Patient Print Name) _____, hereby request and authorize the above medical records, x-rays, MRI /CT, other films and test results to be photocopied, released, and mailed to the above doctor at the indicated address for the specific dates. I understand the Health Insurance Portabiility and Accountablility ACT (HIPPA) applies to my medical records and protected health information. I expect the holder of my medical records to mail my specified medical records as soon as reasonably possible, not to exceed 30 days if kept on site, and 60 days if stored off site, once this request has been received. This authorization may be revoked by me, at any time, by advising the doctor's office (privacy officer) of this revocation in writing. I have bee advised that if I choose to sign this authorization that it will not have any adverse effect on my treatmeant, eligibity for benefits, enrollment, or payment.

It is understood that any X-Ray, CT, or MRI original films will be returned to the original facility within 30 days after the requestind doctors receives them.

Signature of Patient:_____ Date_____