JUNIPER FAMILY CHIROPRACTIC

Patient Records Request & Release Authorization

420 West Avenue, North Augusta, SC 29841
(803) 471-7008 | juniperfamilychiro@gmail.com

Patient Information

Patient's Full Name: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Parent/Legal Guardian (if applicable): _____

Records Requested

Please select one:

- Complete chiropractic record
- Records from a specific date range: _____
- Other (please specify): _____

Where Should We Send Your Records?

Please select one:

- Send a copy directly to me
- Send my records to another healthcare provider

If sending to another provider:

Provider/Practice Name: _____

Provider Phone Number: _____

Provider Secure Email: _____

Authorization

I authorize Juniper Family Chiropractic to release the records specified above to the individual or healthcare provider identified on this form.

I understand that this authorization is voluntary and may be revoked in writing before the requested records have been released. I understand that information disclosed to a recipient may no longer be protected by the same privacy laws.

This authorization expires 90 days from the date signed unless an earlier expiration date is specified below.

Earlier Expiration Date (optional): _____

Patient/Legal Guardian Signature: _____

Date: _____

Relationship to Patient (if applicable): _____

Office Use Only

Date Received: _____

Identity/Authority Verified: _____

Date Records Sent: _____

Method of Delivery: _____

Processed By: _____