RELEASE OF PATIENT RECORDS AUTHORIZATION

CRESTVIEW CHIROPRACTIC CLINIC, INC.
1078 SOUTH FERDON BLVD CRESTVIEW, FL 32536
PHONE 850-682-0381 FAX 850-683-0981

I hereby authorize _____

to release a copy of my patient records or x-rays containing protected health information to Dr. Anita Kelley-Dukes, DBA Crestview Chiropractic Clinic, Inc.

This authorization is given pursuant to Florida Statute 456.057 and HIPPA regulations. I understand that Florida Statue 456.057(10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representative.

Specific description of information to be disclosed:

_____

_____

_____

I understand that I may revoke this authorization at any time by signing the revocation section of this form.

_____ _____
Printed Patient Name Date of Birth

_____ _____
Patient Signature / If Minor Guardian Signature Date

OFFICE USE ONLY

Records were released to_____ who

is personally known to me or has produced _____as identification.
Type of Identification

REVOCATION SECTION

I hereby revoke this authorization.

_____ _____
Patient/Guardian Signature Date

August 2011