



**chirotrendz**  
family chiropractic and wellness center  
keeping things in motion

**AUTHORIZATION TO RELEASE  
MEDICAL INFORMATION**

I hereby authorize ChiroTrendz Family Chiropractic and Wellness Care and any of its appointed assistants to obtain or share the following information from my healthcare record.

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone Number \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**This information is to be shared with or obtained from:**

**CHIROTRENDZ FAMILY CHIROPRACTIC AND WELLNESS CENTER**

18610 E Rittenhouse Road #A101, QUEEN CREEK, AZ 85142

**PHONE AND FAX:** (480) 999-4700 www.ChiroTrendz.com info@ChiroTrendz.com

**I authorize the following entity to share or obtain all or portion of my healthcare record:**

Agency/Business Name \_\_\_\_\_ Contact Name (if applicable) \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**For the purpose of:**

- Changing provider     Consultation     Chiropractic treatment     At the request of the individual  
 Other (please describe) \_\_\_\_\_

**Information to be disclosed:**

- Office notes for date(s) of service \_\_\_\_\_  
 X-ray reports of \_\_\_\_\_ for date(s) of service \_\_\_\_\_  
 MRI reports of \_\_\_\_\_ for date(s) of service \_\_\_\_\_  
 CT scan reports of \_\_\_\_\_ for date(s) of service \_\_\_\_\_  
 Complete healthcare record  
 CD(s) containing images of above marked studies  
 Other (please describe) \_\_\_\_\_

I understand that treatment will not be conditional on whether I sign this Authorization and that this Authorization is voluntary and I have the right to refuse to sign it. I further understand that this Authorization will remain in effect for one year from the date of the signature below, unless I specify a different date here: \_\_\_\_\_. I understand that if I sign this Authorization, I may revoke it later by sending a written notice of revocation to the privacy officer at ChiroTrendz LLC. Note: The only exception to my right to revoke is if ChiroTrendz LLC has already acted in reliance upon the Authorization. The information disclosed pursuant to this Authorization, except information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws. Once signed, I understand that I will be provided with a copy of this Authorization.

\_\_\_\_\_  
Signature of patient/guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient/guardian