RECORD RELEASE REQUEST

I hereby authorize Family Tree Chiropractic & Wellness to: (please check below)

_____ Release records ________ X-rays (must be returned in 30 days)

_____ Obtain records _______ X-rays

To/From: Name of Facility: ____________________________________

Address: ____________________________________

____

I understand that my records may contain information regarding the diagnosis or treatment of HIV (aids virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my authorization for these records to be released:

Print Patient's Name: ________________________ Date of Birth: ____________

Patient's Signature: _________________________ Date: ___________________

I authorize release of my records EXCLUDING information regarding the diagnosis or treatment of HIV, other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment be released.

Print Patient's Name: _________________________ Date of Birth: _____________

Patient's Signature: _________________________ Date: ____________________

8241 Cornell Rd., Ste. 220
Cincinnati, Ohio 45249
513-777-0024
fax 513-777-0036