Fax:_____

Authorization for the Release of Medical Records

Patient Name: _____ **Date of Birth:** _____

I hereby request and authorize:
Dr. Lydell Nunn Chiropractic HealthCare Center
3414 East Market Street
York, PA 17402
717-755-3899 * fax 717-718-0659

____ To Disclose Information: **____ To Receive Information From:**

Provider/Facility: _____

Address: _____

Information to be disclosed please include copies of:

____X Ray Reports **_____Other, specify_____**
____X Ray Films **_____**
____MRI Reports **_____ Last Office Note**

Purpose for disclosure:

_____Treatment **_____Other, specify**

This authorization is effective for one year after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on the information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

_____ **Date:** _____
Signature of Patient

OR

_____ **Date:**_____
Signature of Legal Representative/Relationship
If signing for a minor patient. I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures without patient consent.