**MONSON CHIROPRACTIC CLINIC, P.C.**

3779 North Alpine Road
Rockford, Illinois 61114
Telephone: (815) 633-9115
(815) 633-9152
Fax: (815) 633-8745

# AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL RECORDS AND/OR INFORMATION

Patient's Name: _____ Patient's Number: _____

Date of Birth: _____ Telephone Number: _____

Address: _____ City: _____ State: _____ Zip_____

❖ **I hereby authorize Monson Chiropractic Clinic to release my medical records to:**

Institution or Individual: _____

Phone Number: _____ Fax Number: _____

Address: _____ City: _____ State: _____ Zip_____

____COMPLETE RECORDS

____ X-RAYS AND/OR X-RAY REPORTS

I understand that my refusal to consent to the release of the above-mentioned information will prevent the disclosure of this information. I understand that if this authorization is for the purpose of third party payment, that medical information as may be necessary to process benefits will be disclosed to my insurance company and/or insurance company's review.

I understand that I may revoke this authorization at any time except to the extent that action has already been taken in reliance thereon. This authorization for release of information expires 90 days or _____, unless I revoke it.

_____ _____

Signature of patient or guardian Date