André L. Montgomery, DC

Belden Place
684 Avon Belden Road
Avon Lake, OH 44012
Ph: 440-930-5537
Fax: 440-930-5237

Info@MCCenterInc.com
www.MCCenterInc.com

Authorization for Release of Patient Health Records

Patient's Name: _____ Date of Birth _____/_____/_____

Maiden Name: _____ SS# _____-_____-_____

Authorizes: _____

To release the following information to: MONTGOMERY CHIROPRACTIC CENTER, INC
684 AVON BELDEN RD.
AVON LAKE, OHIO 44012

MCC Staff Only:

❒ Entire Record or Partial Record, including:
❒ Recent History ❒ Daily Chart Notes
❒ Physical Examination ❒ X-ray Films (copies)
❒ X-ray Reports ❒ MRI/CT Reports
❒ NCV/EMG Reports ❒ Discharge Summary

Authorization covers patient care given from: _____/_____/_____ to Present.

Transfer of records is for treatment purposes, expiration not applicable.

Right to Revoke:

I understand that I have the right to revoke this authorization in writing by presenting revocation to the Office Administrator at Montgomery Chiropractic Center, Inc. I understand that revocation will not apply to information that has already been released prior to the written revocation.

Signature:

I understand that the facility cannot condition treatment on whether I sign this authorization. I understand that authorizing the disclosure of this health information is voluntary and I may refuse to sign the authorization. A copy of this authorization is as valid as the original.

Patient's Signature _____ Date _____/_____/_____
(or signature of power of attorney, legal guardian, parent, or parental designated party)

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. _____ initials

Staff Initials _____ Faxed: _____/_____/_____