



André L. Montgomery, DC

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If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.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