LUCAS CHIROPRACTIC CLINIC

1261 Seward Meridian Pkwy, Suite F. Wasilla, AK 99654
Phone: (907) 357-6100 Fax: (907) 357-6102
Bobby A. Lucas, D.C.

REQUEST FOR MEDICAL RECORDS

DATE: _____TO:_____
FAX #:_____

PATIENT'S NAME:
_____DOB:_____

By ***initialing*** the spaces below, I specifically authorize you to disclose the following health information and/or records, if such information and/or records exist to / from Lucas Chiropractic Clinic.

_____Please send the entire medical record (all information) to the above named recipient.

OR

_____All hospital records (including nursing records & progress notes)
_____Operative reports
_____Medical records needed for continuity of care
_____Most recent five-year history
_____Emergency and urgent care records
_____Other:_____

_____ Office chart notes
_____Laboratory reports
_____Pathology reports
_____Diagnostic imaging/X-ray reports
_____Billing statement/Full account

Except to the extent that action has already been taken in reliance upon the authorization, I understand that I may revoke this authorization at any time by giving written notice to the Medial Records Department at CNN. Unless revoked earlier, this authorization will expire **180 days** from the date of signing.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly for doing so.

_____ _____
Signature of Individual or Individual's Legal Representative **Date**

_____ _____
Print Name of Legal Representative (if Applicable) **Date**