Preston Peacock DC DABCO
408 SW Highway 80
Pooler GA, 31322

Phone 912-748-0350
Fax 912-450-0350
Email:Advancedchiro@hargray.com

Authorization for the Release of Medical Records

Patient Name:_______________________________________Date of Birth:___________
(also list maiden name/other names used)

I hereby request and authorize:

Advanced Chiropractic Center
408 SW Hwy 80
Pooler, Ga. 31322

_______**To Disclose information to:** _______**To Receive Information from:**

Provider:____

Address:____

City/State/Zip____

Information to be disclosed include copies of:

_____Entire Record _____X-ray Reports
_____Progress Notes _____X-ray Films
_____Physical Exam forms _____Other, specify:
_____Daily chart notes ________________________________

Purpose for disclosure:
_____ Treatment, Payment OR _____ Other (Specify)__________________

This authorization will be effective for six months after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on 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If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.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 of this information without the specific written consent of the patient or legal representative.