



REQUEST OF RECORDS

[] I hereby authorize the person/entity listed below to release my protected health information (PHI) to include: [] Examinations [] Diagnostic Imaging Reports & Images

Send To: **CORE Chiropractic**
1770 Saint James Place #210
Houston, TX 77056
(713) 622-3300

Via Fax: **(281) 476-6134** Via E-mail: **FrontDesk@CoreChiropractic.net**

Person/Entity Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Patient Name (Printed) _____ Patient Date of Birth _____

Patient Signature (or Authorized Signature if patient is a minor) _____ Date _____

RELEASE OF RECORDS

[] I hereby authorize **CORE Chiropractic** to release my [] protected health information (PHI), [] billing records and [] medical records to the person/entity specified below:

Person/Entity Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

SEND BY: [] Will be picked up in person [] Mail

[] Fax : _____

[] Email : _____

Patient Name (Printed) _____ Patient Date of Birth _____

Patient Signature (or Authorized Signature if patient is a minor) _____ Date _____

• Authorization expires one year from date of authorization, unless revoked in writing