BLUE FEATHER FAMILY CHIROPRACTIC
Dr. Terri A. Hamilton

Authorization to Release Medical Records

Patient Name:_____ Date of Birth:_____

Street Address:_____ City, State, Zip:_____

I, _____ (name of patient), hereby authorize Blue Feather Family Chiropractic and/or any medical facility to release any and all medical information and test results that pertain to me, to the following individual(s):

Name:_____ Phone #:_____ Relationship to patient:_____

Name:_____ Phone #:_____ Relationship to patient:_____

I authorize Blue Feather Family Chiropractic or the medical facility to contact the individual(s) listed above to convey any pertinent information to me, in the event that I am unable to be reached by the facility.

I understand that I may revoke/cancel this authorization by notifying Blue Feather Family Chiropractic in writing of my intent to revoke authorization or change the name(s) of the individuals to whom information is to be released.

_____ _____

Signature of patient Date

Or, if applicable

_____ _____

Signature of Legal Guardian or Personal Rep
Of Patient's Estate Date

_____

Description of Authority to Act for the Patient

_____ _____ _____

Name of Witness Witness Signature Date