PERMISSION TO PROVIDE MEDICAL INFORMATION

I AUTHORIZE Family Chiropractic of Charleston, Inc. to disclose all information regarding the medical history of, physical condition of, illness of and/or injuries to _____ , before, on, and after the illness/accident date of _____ . This information may be given or provided to _____ .

I UNDERSTAND that this information may be used to determine or to verify the extent of my/his/her loss, and to evaluate my/his/her illness/injury arising out of this illness/injury.

I AGREE this authorization will remain valid until revoked by delivery of written notice to Family Chiropractic of Charleston, Inc.

I UNDERSTAND that I (or my representative) am entitled to receive a copy of this authorization.

A photocopy of this form may be accepted as the original.

PATIENT NAME: _____
PATIENT DATE OF BIRTH: _____
PATIENT SOCIAL SECURITY NO : _____
PATIENT ADDRESS: _____
_____

_____ _____
Signature of Patient, Representative, Parent or Guardian Date

THE ABOVE AUTHORIZATION IS HEREBY REVOKED.

_____ _____
Signature of Patient, Representative, Parent of Guardian Date