NORTHERN HOPE
FUNCTIONAL NEUROLOGY AND CHIROPRACTIC

Authorization Release of Records

- Patient name: _____ Date of birth: _____
- I hereby request and authorize:

  Northern Hope Functional Neurology- Chiropractic – Dr. Sara Graber, D.C. D.A.C.N.B.

  Northern Hope Functional Neurology- Chiropractic – Dr. Tony Graber, D.C. D.A.C.N.B.

- To Disclose Information To: _____To Receive Information From: _____

  Provider: _____

  Address: _____

  City/State/Zip: _____

- Information to be disclosed/include copies of:
  - ☐ Entire Record
  - ☐ Progress Notes
  - ☐ Daily Chart Notes
  - ☐ X-Ray Reports
  - ☐ X-Ray Films
  - ☐ CT Scan
  - ☐ PET Scan
  - ☐ MRI (_____)
  - ☐ Bloodwork (_____)
  - ☐ 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.

_____ _____

(Signature of patient) (Date)

OR

_____ _____

(Signature of Legal Representative/Relationship) (Date)

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.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.

Northern Hope Functional Neurology-Chiropractic

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