SOUTHSIDE CHIROPRACTIC
Dr. Anthony Fort

EMAIL COMPLETED FORM TO INFO@CHIROJACKSONVILLE.COM

Patient: _____ **DOB:** _____

I hereby request and authorize: Dr. Anthony Fort, D.C. of Southside Chiropractic to:

☐ disclose information to: ☐ receive information from:

Provider - _____
Address - _____
City/State/Zip - _____
Telephone _____
Fax _____

Information to be disclosed include(s) copies of:

☐ Entire Record
☐ Progress Notes
☐ Physical Exam Forms
☐ Daily Chart Notes
☐ X-Ray Reports
☐ MRI Report
☐ Other; Specify: _____
☐ All of the above

Purpose of Disclosure:

☐ To allow for appropriate treatment modalities, adjusting techniques, exercise regimen and spinal rehab protocols.

☐ Other (specify) _____

☐ Patient has an appointment with us on _____

This authorization will be effective for 6 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 or Responsible Party: _____

Date: _____

4540 Southside Blvd. Suite 1101, Jacksonville, Fl 32216
Ph (904) 996-8660 Fax (904) 996-8650