MEIER
FAMILY CHIROPRACTIC

Dr. Kimberley Meier
Dr. Jeffrey Meier
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ____________________ Date of Birth: ____________________

Previous Name: ____________________ Social Security #: ____________________

I request and authorize ____ to release healthcare information of the patient named above to:

Name: Meier Chiropractic

Address: 3419 Central Ave., Ste. C

City: Billings State: MT Zip Code: 59102

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ____________________

____

☐ All healthcare information

☐ Other: ____

☐ Yes ☐ No I authorize the release of any records regarding previous chiropractic care, x-rays, reports, MRI'S, CAT scans and physical exams to the person(s) listed above.

Patient Signature: ____________________ Date Signed: ____________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.