

**MEDICAL RECORDS RELEASE FORM**

I hereby authorize: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Fax# \_\_\_\_\_ Phone# \_\_\_\_\_

release the following information from the health records(s) of

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Covering the treatment of: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_

The information is to be released to:

Ronald D. Herring, D.C.  
Rodney D. Herring, D.C.  
2011 Gateway Drive  
Opelika, AL 36801  
T: (334) 745-5321 F: (334) 745-5358

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed above.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date