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