Orman Chiropractic

6315 Dempster Ave Morton Grove, IL 60053 847-967-0101

Authorization for Release of Records / X-Rays

Patient's Name: _____ Date of Birth: _____

I hereby authorize the release of the individually identifiable health information about me that is described below. I understand that disclosure may only be made to the persons or organizations described below. If not specifically limited or restricted, the types of information to be disclosed may include, medical, psychiatric or psychological records, records of evaluation and treatment for alcohol or drug abuse, records and results of HIV or AIDS testing, or other sensitive information.

Specific description of health information to be disclosed: _____

Approximate dates of treatment: _____

Purpose of the use or disclosure: COORDINATION OF CARE _____

Persons or organizations disclosing the information:	**Persons or organizations receiving the information:**
_____	**DANIEL ORMAN, D.C.**
_____	**6315 DEMPSTER ST**
_____	**MORTON GROVE, IL 60053**
	(p) 847-967-0101 (f) 847-967-6889

I understand that my decision to sign this form and authorize use and disclosure of my health information is entirely voluntary. I understand that I may revoke this authorization in writing at any time. Unless revoked by me sooner this authorization is valid for ninety (90) days after the date signed by me.

_____ _____

Signature Date

_____

If Necessary, Signature of Parent, Legal Guardian, or Witness