TRU FORM CHIROPRACTIC | DENVER, CO

"BE TRUE TO YOUR BODY, AND YOUR BODY WILL BE TRUE TO YOU"

AUTHORIZATION FOR REQUEST FOR INFORMATION

I hereby authorize True Form Chiropractic and any of its appointed assistants to obtain the following information from the healthcare record of:

Patient Name _____ Date of Birth _____ Phone Number _____

Street Address _____ City _____ State _____ Zip _____

This information is to be received from:

Agency/Business Name _____ Contact Name (if applicable) _____

Street Address _____ City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

For the purpose of (please check one):

- ❑ Changing provider
- ❑ Chiropractic treatment
- ❑ At the request of the individual
- ❑ Other (please describe) _____

Information to be disclosed: ***__PLEASE FAX ALL REPORTS TO _____***__

- ❑ Office notes for date(s) of service _____
- ❑ X-ray reports of _____for date(s) of service _____
- ❑ MRI reports of _____for date(s) of service _____
- ❑ CT scan reports of _____for date(s) of service _____
- ❑ Complete healthcare record
- ❑ CD(s) containing images of above marked studies – **__PLEASE MAIL TO ADDRESS LISTED BELOW__**
- ❑ Other (please describe) _____

Special instructions: _____

_____ _____

Signature of patient/guardian Date

_____

Printed name of patient/guardian

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