



C H I R O P R A C T I C | D E N V E R , C O

"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 720-306-5368*****

- ☐ 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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