
315 Commercial Dr, C-5, Savannah, GA 31406

**Authorization for Release of Medical Information**

Date: \_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize the following persons/organizations and/or any or all of its personnel, information, copies of any and all medical records/progress notes at “Titus Chiropractic”. This authorization shall be considered as continuing; with understanding that I retain the right to discontinue authorization with any entity previously given authorization at any point in time. Should I wish to discontinue providing authorization to an entity I will tell the office of Titus Chiropractic.

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| Name/Organization | *Fax Number* | *Phone Number* | *Address* |
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Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_