We Care Chiropractic Center
Helping to improve your quality of life since 1985!

Authorization to Release Health Care Information:

Patient's Name: _____

Date of Birth: _____

Social Security Number: _____

Address: _____

_____

I request and authorize _____
To release healthcare information of the patient named above to We Care Chiropractic, PC 755 Saltsburg Road, Pittsburgh, PA 15235.

This request authorization applies to:

___ All hospital records (including nurse's records and progress notes)
___ Transcribed hospital records
___ Medical records needed for continuity
___ Most recent five-year history
___ Laboratory reports
___ Pathology reports
___ X-Rays, MRI's, CT Scans
___ Diagnostic imaging reports
___ Clinical office chart notes
___ Dental Records
___ Physical Therapy records
___ Emergency and urgency care notes
___ Billing statements
___ All reports
___ Any and all correspondence

Please release records for the dates of : _____/_____/_____ ----- _____/_____/_____
I have read and understand the following: This authorization is valid for 90 days after the date it is signed.
A photostatic copy is valid as an original. This authorization is revocable at any time.

_____

Signature of patient or patient's authorized representative (if under Age of 18) **Date Signed**

_____

Relationship or status i signed by anyone other than patient (parent, legal guardian, etc.)