ORANGE PARK CHIROPRACTIC CENTER
ARGYLE CHIROPRACTIC CENTER

DR. KEITH A. SCHERTELL
DR. NICK SCHERTELL

RELEASE OF PATIENT RECORDS AUTHORIZATION

I hereby authorize _____ to release a copy of my patient records or x-rays containing protected health information to _____ _____ . This authorization is given pursuant to Florida Statute 456.057 and HIPPA regulations. I understand that Florida Statute 456.057 (10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives.

_____ _____
Patient's PRINTED name Patient's Date of Birth

_____ _____
Patient's or Patient's Legal Representative's Signature Date Signed

Specific description of information to be disclosed: _____

_____

_____

_____

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