Fontanarosa Chiropractic Wellness Center
274 Lafayette Avenue
Hawthorne, New Jersey 07506
Phone: 973-423-9600 Fax: 973-423-0403

Authorization for Release of Patient Records and Information

I, _____, born on _____.
(Name of Patient) (Date of Birth)
do hereby consent and authorize Fontanarosa Chiropractic Wellness Center to request the following type of information from the office records:

___ X-Ray ___History ___Records ___Diagnosis

___Treatment ___Reports ___Billings

and the purpose or need for this request is:
_____

_____

Distribution by:	Type of Media:
Mail: ☐	
Fax: ☐	Film: ☐
Report only: ☐	CD: ☐

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the office manager at Fontanarosa Chiropractic Wellness Center. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this Authorization will expire on the following date, event, or condition:_____INDEFINITE_____

Please indicate type of examination
And approximate date(s) of service:

_____
_____
_____
_____

Patient's Signature_____
(Parent/Legal Guardian or Authorized Representative)

Date_____

Witness Signature_____