Board of Chiropractic Examiners

AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

I, the undersigned hereby authorize:

Chiropractor _____
Facility _____
Address _____
_____
Phone Number _____

Chiropractor _____
Facility _____
Address _____
_____
Phone Number _____

Chiropractor _____
Facility _____
Address _____
_____
Phone Number _____

Chiropractor _____
Facility _____
Address _____
_____
Phone Number _____

to disclose records in the course of my diagnosis and treatment, including medical, psychiatric, alcohol and drug abuse records to the **BOARD OF CHIROPRACTIC EXAMINERS, ENFORCEMENT PROGRAM**. This disclosure of records authorized herein is required for official use, including investigation and possible administrative proceedings regarding any violations of the laws of the State of California. This authorization shall remain valid until the Board of Chiropractic Examiners of the State of California completes its investigation and proceedings arising out of the complaint and/or investigation.

A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization upon my request.

Signature: _____ _____
Patient Date

Or: _____ _____ _____
Legal Representative Relationship Date

Rev. 12/18