ORANGE PARK CHIROPRACTIC CENTER
ARGYLE CHIROPRACTIC CENTER

DR. KEITH A. SCHERTELL
DR. JAMES W. DAUTEL
DR. TINA WARREN

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 or Patient's Legal Representative's Signature Patient's Date of Birth

__________________________________ Date Signed

Specific description of information to be disclosed: _____________________________________

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