AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To:_____

Address:_____

I _____**request the following information:**

- **X-rays History/Records Diagnosis Treatment Reports Billing**

Concerning my: Accident Injury Illness Other

To be released to:_____

_____

_____

For the purpose of:_____

According to Section 123.110 of The California Health & Safety Code, these records/films must be transmitted with in 15 dates from receipt of this notice.

Effective dates for this authorization____/____/____through___/___/____. This authorization will expire at the end of the above period. If no dates are indicated this authorization will remain valid for 30 days.
(Any X-Rays released from La Costa Chiropractic must be returned within 30 days)

Signed:_____**Date:**_____

Patient Parent/Guardian Date of Birth: ____/____/____

Patient Rights:

1. **You may revoke this authorization at any time during the effective dates by sending written notice.**
2. **You may refuse to sign this authorization without negative consequence to treatment.**
3. **You may receive a copy of this authorization.**
4. **You may restrict what is disclosed by this authorization.**

Note: If you refuse to sign the authorization there is no negative consequences to your receiving care or payment or services for or from this office.