Bauman Chiropractic Clinic of Northwest Florida

3613 North Highway 231, Panama City Fl. 32404
Phone: 850-785-8311 Fax: 850-872-9892

MEDICAL RECORDS REQUEST

PATIENT NAME: ____________________________________ DATE: __________________

SOCIAL SECURITY NO: __________________________ DATE OF BIRTH: _____________

ADDRESS: ____

PHONE NUMBER: ________________________ DATE OF LOSS: _____________________

CLAIM NUMBER: ____

FROM: ____________________________

____

____

____

TO: BAUMAN CHIROPRACTIC CLINIC
3613 Hwy 231 North
PANAMA CITY, FL 32404

ڤ **Date Requested** _____________________

ڤ Medical Records ڤ Progress Notes ڤ Any Radiographs or other reports ڤ Other: ____________
SPECIFIC DESCRIPTION OF INFORMATION TO BE DISCLOSED ___________________

THIS AUTHORIZATION IS GIVEN PURSUANT TO FLORIDA STATUTE 456.057 AND HIPAA REGULATIONS. I UNDERSTAND THAT FLORIDA STATUTE456.057(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 LEGAL REPRESENTATIVES.

______________________________________ ______________ ___________________________

PATIENT OR GUARDIAN SIGNATURE **DATE** **WITNESSED BY**

I HEREBY AUTHORIZE BAUMAN CHIROPRACTIC CLINIC OF NORTHWEST FLORIDA P.A. TO RECEIVE A COPY OF MY PATIENT RECORDS OR X-RAYS CONTAINING PROTECTED HEALTH INFORMATION.

DATE FAXED: ____________________________________ **(850-872-9892)**

WILL PICK UP: ____________________________________ **DATE:** ____________________________

DATE MAILED: ____________________________________

I HEREBY ACKNOWLEDGE RECEIPT OF THESE RECORDS AND/OR X-RAYS. IN CONSIDERATION OF THE FOREGOING, I HEREBY RELEASE AND FOREVER DISCHARGE THE AFORESAID DOCTOR OF CHIROPRACTIC FROM ANY AND ALL RESPONSIBILITY OR LIABILITY OF ANY KIND, NATURE, OR CHARACTER WHATSOEVER ARISING FROM SAID TREATMENT.