Lavan Family Chiropractic, LLC
2090 Sugarloaf Parkway, Suite 115
Lawrenceville, GA 30045
678.883.3218 ~ lavanfamilychiropractic@gmail.com ~ www.drlavan.com

AUTHORIZATION FOR REQUEST / RELEASE OF INFORMATION

I hereby authorize Lavan Family Chiropractic, LLC and any of its appointed assistants to obtain or disclose the following information from the healthcare record of:

Patient's Name _____ Date of Birth _____ Phone Number _____

Street Address _____ City _____ State _____ Zip _____

This information is to be received from or disclosed to:

Agency/Business Name _____ Contact Name (if applicable) _____

Street Address _____ City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

For the purpose of (please check one):

- ❑ Moving
- ❑ Changing provider
- ❑ Second opinion
- ❑ Consultation
- ❑ Insurance change
- ❑ Other (please describe) _____

Information to be disclosed:

- ❑ Office notes for date(s) of service _____
- ❑ X-ray reports of _____for date(s) of service _____
- ❑ MRI reports of _____for date(s) of service _____
- ❑ CD(s) containing images of above marked studies – PLEASE MAIL TO ADDRESS LISTED ABOVE
- ❑ Photographs or other images
- ❑ Complete healthcare record
- ❑ Other (please describe) _____

Special instructions: _____

***** PLEASE SEND ALL REPORTS TO THE EMAIL OR ADDRESS LISTED ABOVE.**

I understand that this authorization is valid for 12 months after the date signed, unless cancelled by me in writing. This authorization must be dated subsequent to the period for which the information is requested.

I have read and understand the above statements and do expressly and voluntarily consent to disclosure of the above information to those persons or agencies named above. I hereby release Lavan Family Chiropractic, LLC and any of its appointed assistants from all legal responsibility or liability that may arise from the release of these healthcare records.

_____ _____

Signature of Patient/Guardian Date