Medical Records Release

1. Name: First Name | Middle Name | Last Name

2. Date of Birth: MM | DD | YY

Records to be Released from: Center for Chiropractic and Wellness

Records to be Released to: Adjust-ology Chiropractic and Whole Body Health
8504 Six Forks Rd, Suite 204
Raleigh, NC 27615

Purpose of Release:
This authorization is for **continuation of care**.

Method of Delivery:
All records shall be transmitted **via encrypted email** to office@adjust-ology.com at Adjust-ology Chiropractic and Whole Body Health

Patient Rights and Acknowledgment:
- I understand that this authorization is voluntary and may be revoked at any time by written notice to Center for Chiropractic and Wellness, except to the extent that action has already been taken based on this authorization.
- I understand that once my records are released, they may not be protected under federal privacy regulations if the recipient is not a covered entity under HIPAA.
- I acknowledge that I have read and understood this authorization.

4. Information to be Released

☐ Complete Medical Record

7. Signature | Date of Signature MM | DD | YY