Release of PHI Records

Date: ______________

To: ____________________________
MEDICAL RECORDS DEPT.

Phone: _______________________

Fax: _______________________

From: **Dr. W.H. Ledbetter, III, B.S., D.C. dba**

Accident Relief Chiropractic

Phone: **214-703-9800** Fax: **214-703-8001**

Email: drwilliamledbetter@gmail.com

Re: Medical records for ____

SS#: __________________ DOB: _______________

I, __________________________, request and consent to the release of the following information:

X-rays History Diagnosis Treatment Reports Sensitive Information

concerning: **Accident of** ____________ **Any care given at your facility**

to: **Dr. W.H. Ledbetter, III, B.S., D.C.**

at: **2376 Lavon Dr.,Ste. 134, Garland, TX 75040**

by fax: **214-703-8001** **or** Email: drwilliamledbetter@gmail.com

for the purpose of treatment at that office.

Signed: ____ Date: __________
Patient or Guardian

I certify that the protected health information of the above referenced patient will be used solely for the purposes of treatment, payment, and operations. This facility complies with all applicable federal privacy statutes.

Witness: ____ Date: _________
Privacy Officer