Lynch Chiropractic and Chronic Pain Solutions

Offering customized healthcare solutions to eliminate the cause of your pain.

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RECORDS RELEASE

I, _____ with date of birth _____ authorize the University of Virginia Hospital to release any and all my personal health information, including any blood work, special tests, copies of x-rays and/or MRIs, to Keith P. Lynch, D.C. of Lynch Chiropractic and Chronic Pain Solutions. If Dr. Lynch and/or Lynch Chiropractic and Chronic Pain Solutions need any information from the University of Virginia Hospital, they have my permission to contact them directly.

This authorization regarding sharing my personal health information is effective as of the date of my signing this Records Release and remains in effect until I send the University of Virginia Hospital a statement stating this Records Release is no longer in effect.

Patient Signature: _____(Please sign)

Date:_____(Please insert today's date)

**PLEASE NOTE…We are specifically requesting blood work, x-rays, MRI's other any other imaging within the last year. Thank you.