Provider/Facility: Address: Information to be disclosed please include copies of:	Patient Name:	Date of Birth:
Dr. Lydell Nunn Chiropractic HealthCare Center 34!4 East Market Street York, PA 17402 717-755-3899 * fax 717-718-0659 To Disclose Information: To Receive Information From Provider/Facility: Address:	I hereby request and authorize:	
York, PA 17402 717-755-3899 * fax 717-718-0659	· ·	Care Center
To Disclose Information: To Receive Information From Provider/Facility:		
To Disclose Information:To Receive Information From Provider/Facility:	•	
Provider/Facility: Address: Information to be disclosed please include copies of:	717-755-3899 * fax 717-718-0659	
Address: Information to be disclosed please include copies of: X Ray ReportsOther, specifyX Ray FilmsMRI ReportsLast Office Note Purpose for disclosure:TreatmentOther, specify This authorization is effective for one year after the date signed, unless cancelled writing: I understand that the cancellation will have no effect on the information released prior to receiving the cancellation. A copy of this authorization is as val	To Disclose Information:	To Receive Information From
Information to be disclosed please include copies of: X Ray ReportsOther, specifyX Ray Films Last Office Note Purpose for disclosure:TreatmentOther, specify This authorization is effective for one year after the date signed, unless cancelled writing: I understand that the cancellation will have no effect on the information released prior to receiving the cancellation. A copy of this authorization is as val	Provider/Facility:	
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Date:	Information to be disclosed please X Ray Reports X Ray Films MRI Reports Purpose for disclosure: Treatment This authorization is effective for one your contents of the cancellar released prior to receiving the cancellaters.	Last Office Note Other, specify Last Office Note Other, specify ear after the date signed, unless cancelled in tion will have no effect on the information ion. A copy of this authorization is as valid

Signature of Legal Representative/Relationship
If signing for a minor patient. I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures without patient consent.

Date: