KENTUCKY BOARD OF CHIROPRACTIC EXAMINERS

P.O. BOX 1360
Frankfort, KY 40602
Phone: (502) 892-4250 - Fax: (502) 564-4818
Email: kbce@ky.gov

Authorization for Release of Medical and Chiropractic Records to the Kentucky Board of Chiropractic Examiners

I, ________________________________, the undersigned, hereby authorize the full release of any and
Print full name of patient

all medical records, billing information and medical reports from the chiropractor, physician, or other medical personnel, or any licensed health care facility regarding the medical history, diagnosis and treatment relevant to my initiating complaint, filed against ____ ,
Name of treating Chiropractor

to the Kentucky Board of Chiropractic Examiners, or any authorized agent or investigator of the Board. The Board's address is: P.O. Box 1360, Frankfort, KY 40602. Copies of such documents may be mailed to the Board at this address or hand-delivered to any authorized agent or investigator of the Board. A photocopy of this authorization shall be deemed as effective as an original. This authorization shall be effective for one year from the date of signing.

_________________________   ____
Date   Signature of patient or legal guardian of patient