Clock Tower Chiropractic and Massage

AUTHORIZATION TO RELEASE X-RAYS AND INFO

Patient Name _____ DOB_____

Release to (Provider):_____

Address_____

City_____ ST_____ Zip_____

Phone_____ Fax_____

I, _____, request the following information:

( ) X-Ray ( ) MRI ( ) History ( ) Diagnosis ( ) Treatment ( ) Reports

Concerning my, ( ) Accident ( ) Injury ( ) Illness ( ) Other

Released from _____

Address_____

City_____ ST_____ Zip_____

Phone_____ Fax_____

For the purpose of ( ) Treatment ( ) Review ( ) Referral

I Understand That I Have The Right To Receive A Copy Of This Authorization Upon My Request.

Signed_____Date_____

( ) Patient ( ) Spouse ( ) Parent ( ) Guardian

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