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**Clock Tower Chiropractic & 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 ( ) Other: _____

**I UNDERSTAND THAT I HAVE THE RIGHT TO RECEIVE A COPY OF THIS AUTHROIZATION UPON MY REQUEST**

Signed: _____ Date: _____

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