AUTHORIZATION FOR RELEASE OF RECORDS

Date: _________________

Re: ____

To: ____
Doctor/Hospital

Address: ______________________________________

____

Phone: ______________________________________

Fax: ______________________________________

I, ____________________________________, hereby authorize the release of my records and x-rays, or copies of such, and request that they be transferred to:

Hornback Chiropractic and Wellness, P.A
11023 Gatewood Dr. Suite 101
Bradenton, FL 34211
Ph. (941) 744-1585 Fx. (941) 744-1572
www.hornbackchiro.com

Date of Records: __________________

Patient's Name: ______________________________________

Patient's Date of Birth: ______________

Patient's Signature ____________________________________Date: ________