CHIROPRACTIC
HEALTHCARE CENTER

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I (Patient's Name) **_____ date of birth: ____/____/____ request a copy of that my medical / chiropractic records.**

Please Choose how you would like to receive the copy of records

( ) I would like to pick the records up from the office at 618 BROADWAY ST, MARBLE FALLS, TX 78654

( ) I would like the office to FAX the records to:

MY private line: _____-_____-_____

or to my provider: (Name) _____

Private Line: _____-_____-_____

( ) I would the office to mail the records to:

Name: _____

Address: _____

City/State/Zip: _____

Please attach a copy of your driver's license with this request.

Send the request to: **FAX#** *830-201-4375 or* **Mail** *to: 618 Broadway St, Marble Falls, TX 75654*

Signature: _____ Date:_____

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