

Patient Authorization to Release Information

Check one of the following boxes

- I hereby authorize the *Health Care Facility* named below to release the *Requested Information* to:

Complete Chiropractic and Wellness
6640 Lyndale Avenue S, Suite 120
Richfield, MN 55423
Ph: (612)866-1859
Fax: (612)866-2404

- I hereby authorize Complete Chiropractic and Wellness to release the *Requested Information* to the *Health Care Facility* named below.

❖ Please fill out the following completely. Please print legibly.

Health Care Facility

Facility: _____ Phone: _____

Doctor: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Patient

Name: _____ Date of Birth: _____

Address: _____ SSN#: _____

City: _____ State: _____ Zip Code: _____

Requested Information

- Complete Medical Records
 Complete Radiological studies (Include X-ray, MRI, CT, etc.)
 Other _____

Patient signature _____ Date _____