PATIENT NAME: DOB: DATE:

**HEALTH AND MEDICAL INFORMATION RELEASE:**

By signing this form, I give permission to Dr. Glen S. Thornton and the employees of Thornton Chiropractic Center to share my personal medical information with the following medical providers / offices and their staff. Also, the following medical providers / offices have permission to share my personal medical information with Dr. Glen S. Thornton and the employees of Thornton Chiropractic Center.

 Name of Doctor or Office:

 Address:

 City, State, Zip:

 Phone Number:

 Name of Doctor or Office:

 Address:

 City, State, Zip:

 Phone Number:

 Name of Doctor or Office:

 Address:

 City, State, Zip:

 Phone Number:

 Name of Doctor or Office:

 Address:

 City, State, Zip:

 Phone Number:

 Name of Doctor or Office:

 Address:

 City, State, Zip:

 Phone Number:

SIGNATURE: Date: