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:

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Address:

City, State, Zip:

Phone Number:

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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: