MADDAS CHIROPRACTIC & REHAB CENTER

870 McClellandtown Road
McClellandtown, PA 15458
Phone: (724) 430-4924

4313 State Route 51
Rostraver, PA 15012
Fax: (724) 430-4925

PHONE: 724-430-4924 **FAX: 724-430-4925**

REQUEST AND AUTHORIZATION FOR RELEASE OF MEDICAL AND/OR HOSPITAL RECORDS

Patient's Name: ____

Social Security Number: ____

Date of Birth: ____

Date of Accident: ____

I, _________________________, the undersigned, hereby give my permission and this is your authority to permit, Dr. Aaron D. Maddas to receive, request, examine, make, or be furnished with copies of any medical and/or hospital records or information to the above matter.

I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original.

I understand that I have the right to revoke this authorization at any time by sending in a written request.

Date: ____

Signature: ____