

AUTHORIZATION FOR RECORDS RELEASE

Date:

To: Medical Records / Radiology _____

Dear Sir or Madam:

I hereby authorize the release of my medical records. Please send/fax them A.S.A.P. to the address / fax number below.

ITEMS BEING REQUESTED:

Thank you for your attention towards this request.

Sincerely,

X _____

Signature (Signature of parent/legal guardian if under 18 years of age)

----- D.O.B.

Print Name

Send / FAX Records to:

Brian Daniels, D.C.

Daniels Chiropractic Office

363 Massachusetts Avenue

Lexington, MA 02420

Telephone (781) 676-0008

FAX (781) 676-0014