CONFIDENTIAL

Mills River Family Chiropractic

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Chiropractic Physicians

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Records Release

To: ______________________________
Phone: ___________________________
Fax: _____________________________

I authorize you to release to **Mills River Family Chiropractic, PA** the following information:

____Medical Records
____Exam Findings
____Treatment
____X-Rays / Report
____MRI / Report
____CT Scan / Report
____Lab Results
____Other ________________________________

_________________________________ (Printed Name)

______/_____/______ (DOB)

_________________________________ (Signature) (Date)

_________________________________ (Witness) (Date)

MRFC REV 07