AUTHORIZATION TO RELEASE INFORMATION

To: _____

Phone: _____ Fax: _____

Patient Name: _____ DOB: _____

Please release the records indicated below to _____ for the purposes of diagnosis and treatment.

☐ Records ☐ Diagnosis ☐ Treatment ☐ Reports ☐ Imaging Reports

☐ Other: _____

Signature: _____ Date: _____

☐ Patient ☐ Parent ☐ Guardian

Please send records via:

☐ Fax: _____

☐ Email: _____

☐ Mail: _____

_____

_____

_____

PINNACLE CHIROPRACTIC SYSTEM

Rev. 1/3/2022