RECORDS RELEASE/ AUTHORIZATION

TO: Facility and or treating Doctor: ____

____

Address:

____

Fax:

I hereby authorize and request you to release to:

FAMILY CHIROPRACTIC AND ACUPUNCTURE
DR. Sara C. Miller
3105 Western Branch Boulevard #4
Chesapeake, VA 23321
PH: (757) 686-3716 - FAX: (757) 686-8851

A BRIEF history in your possession concerning my illness and/or treatment.

MRI REPORT______ XRAY REPORT______ IMAGING/LAB REPORT____

NAME:____ DATE:__________________

ADDRESS:____

CITY/STATE/ZIP____

SIGNATURE:______________________________ SS#:__________________________

WITNESS:____