

PROVIDENCE FAMILY CHIROPRACTIC CENTER, P.L.L.C.

Authorization for Medical Information

Date: _____

I, _____, authorize the release of my x-rays and other related health records to Providence Family Chiropractic Center.

Patient Signature: _____

Patient Address: _____

Patient Date of Birth: _____

This authorization of photocopy thereof will authorize a physician, hospital, clinic, or other medical institution to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-rays and any physical findings, diagnosis, and prognosis. In accordance with public statute receipt of this document requires providing requested information expeditiously.

5328 IVAN DR. · LANSING, MI 48917