AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I,_____

DOB_____authorize_____

to release the following medical information to Northwoods Family Chiropractic any and all medical records including imaging and reports, i.e. x-rays, MRI, CT, etc.

Please send films to the following address:

Northwoods Family Chiropractic, P.C.
202 W. Adams St.
Iron River, MI 49935

Northwoods Family Chiropractic, P.C.
337 Superior Avenue
Crystal Falls, MI 49920

Please fax records to the following phone number:

Northwoods Family Chiropractic (Iron River)
(906) 265-9009

Northwoods Family Chiropractic (Crystal Falls)
(906) 874-0112

This information is being released for diagnostic and treatment purposes only and may not be used for any other purpose or released to any other person(s) without my written consent.

This release is effective until it is revoked by me at any time by providing notice in writing to the above-named party.

_____ Date: _____
Patient

_____ Date: _____
Parent/Guardian

_____
Witness