

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I, \_\_\_\_\_ parent  
of \_\_\_\_\_ DOB \_\_\_\_\_  
authorize \_\_\_\_\_ to release the following medical  
information to Northwoods Family Chiropractic P.C. 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.

\_\_\_\_\_  
Patient Date: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Date: \_\_\_\_\_

\_\_\_\_\_  
Witness