AMMONS CHIROPRACTIC CLINIC

I _____
(print name)

authorize ( )
do NOT authorize ( )

Ammons Chiropractic Clinic to request my records about my present condition from my doctor

_____ at _____
(name of doctor) (office name)

and I
authorize ( )
do NOT authorize ( )
Ammons Chiropractic Clinic to release my records to my doctor.

_____ _____
(patient signature) (patient date of birth)

_____
(today's date)

_____
(Parent/guardian signature if a minor)

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