



Select-Care Chiropractic, PC

Nutrition • Chiropractic • Wellness
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AUTHORIZATION FOR RECORDS RELEASE

This authorization or photocopy hereof, will authorize Select-Care Chiropractic, P.C. to furnish and/or receive all information regarding my health care while under their observation or treatment, including the history obtained, diagnostic testing, physical findings, diagnosis and prognosis from the following offices/Doctors:

(PRINT PATIENT NAME)

(PATIENT SIGNATURE)

____ Chiropractor: _____

____ Primary Care Physician: _____

____ Pain Clinic: _____

____ Neurologist: _____

____ OBGYN/Midwife: _____

____ X-rays, MRI, CT, EMG (where): _____

____ Surgical Notes (not indicated above): _____

____ Other: _____