AUTHORIZATION TO RELEASE PATIENT INFORMATION & MEDICAL RECORDS

TO: ______________________________
Provider Name

____
Provider Address

____
City, State and Zip Code

____
Provider Fax Number

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by him/her/them, all records and reports, including X-rays and photostatic copies, abstracts or excerpts of all records and any other information he/she/they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future. Please forward the reports and information requested to:

Yen Chiropractic LLC
4528 W. Craig Rd Ste. #190
North Las Vegas, NV 89032
Tel: (702) 685-8776
Fax: (877) 669-1370
Email: yenchiropractic@gmail.com

____
Patient Signature

____
Print Your Name

____
Patient Street Address

____
City, State and Zip Code

____
Patient Date of Birth

____
Dated Authorization Signed