BACK 2 BACK CHIROPRACTIC
A Family Wellness Place

Authorization to Release X-Ray Report/Medical Records

Patient Name (print):_____ **Date of Birth:**_____

Authorization Date: _____ **Expiration Date:** _____

I herby authorize Back 2 Back Chiropractic and its affiliates to release my:

_____ Radiology Report _____ X-Ray Records

_____ Medical Reports/Records _____ Billing & Ledger Information

Or copies of such and request that they are to be transferred to:

To: _____
(Doctor/Hospital/Attorney/Insurance Company)

Address: _____

City: _____ **State:** _____ **Zip:** _____

Patient's Signature: _____ **Date:** _____

Witness: _____ **Date:** _____