AUTHORIZATION FOR RECORDS RELEASE

Date:___ / ___ / 20___
To: Medical Records / Radiology_____

Dear Sir or Madam:

I hereby authorize the release of my medical records. Please send/fax them A.S.A.P. to the address / fax number below.

ITEMS BEING REQUESTED:

Thank you for your attention towards this request.

Sincerely,

X_____
Signature (Signature of parent/legal guardian if under 18 years of age)

_____ **DATE OF BIRTH**:
Print Name

Send / FAX Records to:
Brian Daniels, D.C.
Daniels Chiropractic Office
363 Massachusetts Avenue
Lexington, MA 02420

Telephone (781) 676-0008 **FAX (781) 676-0014**