CHIROPRACTIC PARTNERS, S.C.

AUTO AND WORK INJURIES • SPORTS INJURIES • FAMILY PRACTICE • NUTRITION AND WELLNESS CARE • MASSAGE AND PHYSIOTHERAPY

RECORDS RELEASE

I hereby authorize the release of my x-rays and/or medical records to:

____

____

____

Patient Name: ________________________________Case / Account # ______________

Films: 8 x 10 _______ 12X 14 _______ Total Films : ________

The x-ray films represent a part of this patient's permanent records at this office; ***please return.***

Date: ______________ Patient's Signature: ____________________________________

Date: ______________ Witness Signature: ____________________________________

Dr. Dan P. Killian Dr. William F. Schneider Dr. Brett C. Pape

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