CHIROPRACTIC PARTNERS, S.C.

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

AUTHORIZATION AND CONSENT TO RELEASE MEDICAL RECORDS / X-RAYS

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

Chiropractic Partners, S.C.
1720 Dolphin Drive, Suite E
Waukesha, WI 53186

Fax (262) 547-7441

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____