PATIENT CONSENT FOR REQUEST/RELEASE OF RECORDS

Heartland Clinic of Chiropractic
972 College Street
P.O. Box 166
Monticello, GA 31064
706-468-6500
FAX:706-468-5497

I ______________________ hereby authorize Dr. Lyndsy Johnston with Heartland Clinic of Chiropractic to request/release and/or confer my progress/medical records ie; X-Rays, reports, daily treatment notes and exam forms.

____
(Doctor/Hospital)

Address:____

City:___________________________State:_________Zip:_____________

Phone number:____

____
Date of Records

____
Patient's Date of Birth

____
Patient's Signature

Date:________________