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 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:_____