



**CRESCO CHIROPRACTIC CLINIC P.C.**

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**Authorization To Release Records**

**1. PATIENT INFORMATION**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

SSN/ID#: \_\_\_\_\_

DOB: \_\_\_\_\_

**2. AUTHORIZATION FOR RELEASE**

I hereby authorize \_\_\_\_\_ to release, disclose, and deliver the information described below to Cresco Chiropractic Clinic.

**3. SPECIFIC AUTHORIZATION**

I specifically authorize the release of the following information from my records;

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date