AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, ___________________________________, request the following information:

□ Records □ X-Rays □ MRI/CT Reports
(Please allow **1-2 business days** for x-rays and **10-15 business days** for medical records. We will notify you when records are ready for pick-up)

To be released From: ☐ To: ☐ To be release From: ☐ To: ☐

Hands on Health Chiropractic
3500 William D. Tate, Suite 175
Grapevine, TX 76051
(817) 421-4775 office
(817) 421-4303 fax

____
____
____
____
____

Thank you.

Authorized Signature: _________________________________

Patient Date of Birth: __________________________________

Today's Date: ________________________________