



RECORDS RELEASE

I authorize the release of any and all of my medical records to the office of:

Minnesota Chiropractic and Rehabilitation
1025 Evergreen Lane
Plymouth, MN 55441

Please forward the following information:

- Complete Medical Records
- Complete Radiographic Films
- Other (Specify): _____

Patient's Name: _____

Patient's Address: _____

Patient's Phone #: _____

Patient's DOB: _____

Patient's Signature: _____ Date: _____