RECORDS RELEASE/ REQUEST

To____

I hereby authorize the release of my ____________________

____

____

or copies of such and request that they be transferred to:

CASSES CHIROPRACTIC CLINIC
313 SOUTH HANOVER STREET
CARLISLE, PA 17013
TELEPHONE: (717) 249-0055
FAX: (717) 249-0087

____

Print Name of Patient

D.O.B.: ____

____

Patient's Signature

Date: ____