Dr. Jon Alan Smith
(256) 891-7040
Fax (256) 891-2301

RELEASE OF RECORDS

To Whom It May Concern:

I_____, request that my health records, reports, and /or x-rays, or a copy thereof, being in the custody of another health care provider be released by fax or mail to Family Chiropractic.

I understand that I am responsible for any costs incurred in copying and mailing these records.

_____

Patient's Signature

_____/ /_____

Patient's Date of Birth

_____

Patient's Social Security Number

_____/ /_____

Today's Date

_____

Witness