



Authorization for Release of Records to be Transferred

To: _____

From: _____

I hereby request and authorize you, your employees, and agents to furnish to the person(s) listed below or anyone designated in writing by him/her/them, all records and reports, including X-rays and photostatic copies, abstracts or excerpts of all records and any other information he/she/they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.

Please forward the reports and information requested to:

Doctor: _____
Address: **9302 N. Meridian St. Ste 170**
Indianapolis, IN 46260

I understand that all records, including diagnostic imaging studies, are the property of Chiropractic Neurology Center and therefore I will be charged a duplication fee upon request of file release.

Name of Patient (Please Print): _____

Date of Records: _____

Signature: _____

Street Address: _____

City, State, Zip: _____

Date of Birth: _____

Signature of Parent or Guardian: _____

Today's Date: _____