RELEASE OF RECORDS

Date_____

Patients Name:_____

To: _____

_____

_____

I HEARBY AUTHORIZE AND REQUEST YOU TO RELEASE

MY_____TO:

DR._____
Suffolk Chiropractic Rehabilitation,P.C.
439 William Floyd Parkway
Shirley N.Y. 11967
Phone 631 772-7000 Fax 631 772-7003

Signature_____ Witness:_____