



ATTENTION: MEDICAL RECORDS

I, _____ release my X-RAYS MRI REPORTS HEALTH RECORDS
to Heartland Chiropractic and Wellness Center.

FROM: Facility/ Physician: _____

Phone _____ **Fax** _____

FROM: Facility/ Physician: _____

Phone _____ **Fax** _____

Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

PATIENT: _____
Name (Print)

Date of Birth: _____

Social Security# _____

Signature: _____

Date: _____