



CURRY CHIROPRACTIC CENTER

DR. GEORGE B. CURRY

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## Medical Release Form

**Patient Information:**

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

I hereby authorize and request the release of my medical records to:

**Physician/Hospital:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

Email: \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Witnessed by:** \_\_\_\_\_