14311 Reese Blvd. West, #A1
Huntersville, NC 28078
704-727-0784 • 888-758-9829 (FAX)
info@AceFamilyChiropractic.com

Authorization For Release of Information

Patient Name: _____ DOB: ___/___/___ SSN: _____
Address: _____

I hereby authorize and request that my ☐medical records ☐x-rays concerning my illness and or treatment starting with date _____ to _____ be released from:

_____
Institution

_____
Address

_____
City, State Zip

_____
Phone

_____
Fax

I would like the requested information be ☐mailed ☐faxed to:

Ace Family Chiropractic
14311 Reese Blvd. West, Suite A1
Huntersville, North Carolina 28078

704-727-0784
888-758-9829 (Fax)
info@AceFamilyChiropractic.com
www.AceFamilyChiropractic.com

I certify that I am:
____ the patient
____ the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. I am the patient's (relationship) _____.

Signature (Patient / Guardian)	Print Name	Date