**PATIENT RELEASE OF RECORDS**

**I hereby authorize Wellesley Chiropractic Office to release a copy of my records and request they be sent to:**

|  |  |
| --- | --- |
| Name | Office Name |
|  |  |
| Street Address | Apt/Suite |
|  |  |
| City | State | Zip/Postal Code | Phone |
|  |  |  |  |
| Email |
|  |

|  |  |  |
| --- | --- | --- |
| Patient Name | Patient Date of Birth | Patient Social Security No. |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| Signature | Print Name | Today’s Date |
|  |  |  |
| Relationship to Patient |
| SELF PARENT GUARDIAN |