AUTHORIZATION TO RELEASE
MEDICAL INFORMATION

TO: (PROVIDER)_____

ADDRESS:_____Fax _____

I,_____ REQUEST THE FOLLOWING INFORMATION:

XRAYS _____
RECORDS _____
DIAGNOSIS_____
TREATMENT _____
REPORTS_____

CONCERNING MY: INJURY _____
ILLNESS _____

TO BE RELEASE TO: PIMA CHIROPRACTIC INC.
DR. KURT H WILSON, D.C.
5806 E PIMA STREET
TUCSON, ARIZONA 85712

(520) 722-1585 fax (520) 886-3452

FOR THE PURPOSE OF :_____-
(specify)

PLEASE PROVIDE THESE RECORDS TO DR. WILSON WITHIN 15 DAYS OF RECEIPT OF THIS REQUEST..

THANK YOU,

SIGNED:_____

PATIENT_____ SPOUSE_____ PARENT_____ GUARDIAN_____

DATE_____