Records Release Authority

To: _____

Doctor or Hospital

Address: _____

City: _____ State: _____ Zip: _____

I Hereby authorize and request release to:

Escobar Chiropractic LLC

912 Colfax Ave,

Winter Park, FL 32789

P: 407-644-3223 Fax: 407-960-3767

The complete medical history, imaging and records in your possession concerning my illness and/or treatment during the period from _____ to _____

Patient name: _____ DOB: _____

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____