

Health and Medical Information Release Form

I, _____, give permission to Shaffer Chiropractic Clinic to share medical information with my medical doctor, _____, as well as his/her staff. Also, my medical doctor and staff have permission to share medical information with Shaffer Chiropractic Clinic.

Signature: _____ Date: _____

Patient Information

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Date of Birth: _____

Medical Doctor Information

Name of Doctor: _____

Address: _____

City, State, Zip: _____

Phone: _____