



Hammer Chiropractic

AND REHABILITATION

840 Arthur Drive · Milton, WI 53563 · t 608 868 4343 · f 608 868 5181

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby
Authorize

_____ (Doctor or Hospital)

Address: _____

City: _____ State: _____ Zip Code: _____

To release the following information from my health care records

1. Medical/Health file
2. Office Notes
3. Narrative Reports
4. X-rays
5. _____

and request the be released to:

Hammer Chiropractic, LLC
840 Arthur Drive
Milton, WI 53563

Or:
Dr./Attorney: _____

(Print Name of Patient)

(Date of Birth)

(Patient Signature)

(Date of Signature)