AUTHORIZATION FOR RELEASE OF RECORDS

To: _____(Attorney/Doctor/Hospital)

_____ (Street Address)

_____ (City, State, Zip)

_____ (Phone)

I hereby request you to release to

Dr. Molly Keefe or her agent at
Back to Health Family Chiropractic
128 North Main Street
St. Albans, VT 05478

802-527-2225
802-527-2013(fax)
call for e-mail address
drmolly.com

any and all health records in your possession, including x-rays and oral discussions, concerning the undersigned.

Signed: _____ Date: _____

Witness: _____ Relationship: Chiropractic Assistant