DEMETREE
CHIROPRACTIC
GROUP

MATTHEW C. DEMETREE, D.C.
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(407) 324-8222

NEW PATIENT "AUTHORIZATION TO RELEASE RECORDS" FORM

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

RE: _____

DOB: _____

SS#: _____

TO: _____

Address: _____

_____

I hereby authorize the release of any and all medical records and radiology reports/films as requested in this authorization by:

Matthew C. Demetree, D.C.
3505 S. Orlando Drive
Sanford, FL 32773
Phone: (407) 324-8222
Fax: (407) 324-8998

_____ _____
Signature Date

_____ _____
Witness Date