CROSSROADS CHIROPRACTIC

Adult Health and Pediatric Development
Now with three convenient locations
*Pembroke * Meredith * Epping*
www.CrossroadsChiropractic.com

AUTHORIZATION FOR RELEASE OF RECORDS

_____ _____
Patient's full name (please print) Date of Birth

I hereby authorize:

☐ Crossroads Chiropractic
Stephanie A.F. Mills, DC
556 Pembroke Street
Pembroke, NH 03275
Phone/Fax: 603.224.4281

☐ Crossroads Chiropractic 125
David A. Medina, DC
629 Calef Highway, Suite 103
Epping, NH 03042
Phone/Fax: 603.679.3222

☐ Crossroads Chiropractic Lakeside
Graham D. Moneysmith, DC
3 Annalee Place
Meredith, NH 03053
Phone/Fax: 603.677-1444

to release x-rays take of me to:

_____
Name

_____
Address

_____
City State Zip

_____ _____
Phone # Fax #

☐ I understand that these x-rays are film originals; they are part of official medical records which belong to Crossroads Chiropractic. I accept responsibility for their care and prompt return.

☐ I am requesting a digital copy of my x-rays. The fee for this is $10.

_____ _____
Signature of patient or legal representative/guardian Date

_____
Authority or relationship of representative

For office use only

Date received: _____
Request completed by: _____ Date completed: _____
Delivery method: ☐ In person ☐ Mail ☐ Other: _____