CROSSROADS
CHIROPRACTIC

Adult Health and Pediatric Development
Pembroke | Meredith | Epping | Bedford
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. Ryan, 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 Bedford
Brooke A. Mills, DC / John Schuessler, DC
Village Shoppes Route 101
Bedford, NH 03110
Phone: (603)575-9080

□ Crossroads Chiropractic Lakeside
Graham D. Moneysmith, DC
3 Annalee Place
Meredith, NH 03053
Phone/Fax: (603)677-1444

to release x-rays taken 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: _____