AUTHORIZATION FOR RELEASE OF RECORDS

Date: _____

RE: _____

To: _____
(Doctor / Hospital / Imaging Center)

Address: _____

_____

Phone: _____

Fax: _____

I, _____, hereby authorize the release of my records and/or X-Rays, or copies of such, and request that they be transferred to:

Dr. Steven S. Youker, D.C., P.A.
YOUKER CHIROPRACTIC & MASSAGE
3825 East State Road 64, Suite 200
Bradenton, Florida 34208
(941) 750-6200
Fax (941) 750-9200
www.youkerchiro.com

Date of Records: _____

Patient's Name: _____

Patient's Date of Birth: _____

Patient's Signature: _____ Date: _____