California Chiropractic Boshears, Inc.
35191 Yucaipa Blvd.
Yucaipa, CA 92399
PHONE: (909) 790-5005
FAX: (909) 790-5009

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Release To:__ ____
____
____

This consent to release information about a patient is intended to satisfy the requirements of California Law (California Civil Code S56 el Seq).

Patient's Name____
Address____
Telephone Number____
Maiden, Former, Or Other Names Used___________________________________
Date of Birth____

The undersigned duly authorized the release of Medical Information concerning the above patient from the following facility:

______California Chiropractic______________________________________
______35191 Yucaipa Blvd.____
______Yucaipa, Ca. 92399____
City State Zip

Physician Requesting Information:__________________________________

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance heron, and if not earlier revoked, it shall terminate six (6) months from date of consent without express revocation.

Diagnosis, care, and treatment for Alcohol Abuse or Drug Abuse or Mental Health Records are included in this request.

Patient or Legal Guardian____
Relationship____
Date Mailed____

A copy of this release to be placed in the patient's chart.