Old Mill Chiropractic
Samuel E. Durbin, D.C.
235 Jungermann Rd., Suite 209
St. Peters, MO 63376
Phone: (636) 928-7387
Fax: (636) 928-1269
www.spinedude.com

Authorization for Release of Records

Today's Date: _____

Name of Patient: _____ Date of Birth: _____

I certify that I am the patient named above and I am requesting a limited, one-time authorization to release my records to Old Mill Chiropractic for the purpose of chiropractic evaluation/treatment. I understand that authorizing the disclosure of this health form is voluntary. I understand that I may inspect the information to be used or disclosed.

Patient Signature: _____

I hereby authorize:

Doctor/Facility Name: _____

Address: _____

Address: _____

Phone: _____

Fax: _____

To release my: ____X-Rays ____ Radiology/MRI/CT Scan Reports ____ Medical Records ____ Lab Results

Date of Records: _____

or copies of such and request that they be faxed or mailed to:

Old Mill Chiropractic
Samuel E. Durbin, D.C.
235 Jungermann Rd., Suite 209
St. Peters, MO 63376
Phone: (636) 928-7387 Fax: (636) 928-1269