Halle Chiropractic, LLC
1857 N. Kolb Rd
Tucson, AZ 85715
PH: 520-290-2229
Fax: 520-290-2236

Date: _____

To: _____
_____
_____

I hereby authorize the release of my X-rays and/or copies of all records and request that they are transferred to:

_____

_____

C/O Halle Chiropractic, LLC
1857 N Kolb Rd
Tucson, AZ 85715
Ph: 520-290-2229
Fax: 520-290-2236

_____

Patient Name (Please print) DOB:

_____

Patient Signature

Please print, sign and fax.