Gray Clinic of Chiropractic

207 EAST OAK STREET
SUITE A
MAHOMET, IL 61853
TELEPHONE (217) 586-3886

TO: ____________________

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Authorization to Release Patient Information & Medical Records

I hereby request and authorize you, your employees, and agents to furnish the GRAY CLINIC OF CHIROPRACTIC, Ltd., all records and reports, including X-Rays and Photostat copies, abstracts, or excerpts of all records and any other information they may request relating to any examination, treatment, or opinion concerning any condition that I may have had in the past, now have, or may have in the future.

Please forward this requested material to:

GRAY CLINIC OF CHIROPRACTIC, Ltd.
207 E. Oak Street, Suite A
Mahomet, IL. 61853

Thank you for your time and effort in honoring this request.

Patient Signature: ____________________

Patient Name Printed: ____________________

Patient Address: ____________________

Patient Telephone #: ____________________

Today's Date: ____________________