



Lake Cities Chiropractic Center

4451 FM 2181 Ste. 120 Corinth, TX 76210 P: 940-497-3147 F: 940-497-3148 E-mail: llake000@centurytel.net

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to
release healthcare information of the patient named above to:

Name: Dr. Taylor Scott, Lake Cities Chiropractic Center

Address: 4451 FM 2181 Ste. 120

City: Corinth State: TX Zip Code: 76210

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information Treatment Notes X-Ray MRI CT Reports

Other: _____

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.