HEALTH & WELLNESS CLINIC

CHIROPRACTIC **WELLNESS**

AUTHORIZATION TO ACCESS PATIENT'S RECORDS

Patient Name: _____ File #:_____

Person(s) Authorized to Access Patient's Records: _____

_____

_____

I do hereby authorize the above mention person(s) to discuss any and all of my care, treatment and procedures with Dr. Murphy and access my confidential records at any time.

_____
PRINT NAME

_____
SIGNATURE

_____
DATE

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