…like music to the spine

CONSENT TO RELEASE MEDICAL RECORDS

To: MEDICAL RECORDS

Date: ____________________________

Patient Name: _____________________

Agency: _______________

Date of Birth: _____________________

SS#: _____________________________

The undersigned person(s) hereby consent to, and by this authorization or any photocopy hereof authorizes, the release to:
Elite Healthcare Alliance; Dr. Joseph Clay, D.C. 350 N Mart Plaza Suite B; Jackson, MS 39206.
Any hospital, medical clinic, surgeon, physician, or any other provider of medical services, treatment, or supplies for:

____

(Patient and patient's address)

DATE(S) OF REFERENCE: _______________

DATE OF EXPIRATION: ________________

Please release my:

____ Lab Results – Please fax to the number below.
____ Emergency Room Records ONLY- Please fax or mail to the number below.
____ Images-Please **Mail** to the address below or **email** to **recordsandbilling@ehachiroms.com**
____ Medical Records - Please **fax** or **email** to **recordsandbilling@ehachiroms.com**
____ Imaging Reports - Please **fax** or **email** to **recordsandbilling@ehachiroms.com**

Patient's/Guardian's Signature: ____