…like music to the spine

## CONSENT TO RELEASE MEDICAL RECORDS

To: MEDICAL RECORDS
And/Or IMAGES

Agency: _____

Date: _____

Patient Name: _____

Date of Birth: _____

SS#: _____

The undersigned person(s) hereby consent to, and by this authorization or any photocopy hereof authorizes, the release to:
**EHA - Dr. Joseph Clay, D.C. 6512 DOGWOOD VIEW PKWY SUITE D; Jackson, MS 39213**.
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: _____