1709 S. Coast Hwy Oceanside, Ca. 92054
Phone (760) 967-7444 **Fax (760) 967-7445** **www.droceanside.com**

Authorization to Release Chiropractic Records / Radiographic Images

I ______________________ (patient name) authorize Dr Oceanside Chiropractic to release all chiropractic files and/or radiographic images to:
Please check box as appropriate

Clinic Name: ____
Doctor Name: ____
Address: ____
Tel: _____________________________ Fax: _________________________
E-mail: ____

as of ________________ (date).

____ _______________
Patient Signature Date

____
Patient Print Name

Authorization to Obtain Chiropractic/Medical Records and Radiographic Images

I _____________ (**patient name**) authorize the release of all medical/chiropractic files and/or radiographic images requested to Dr Oceanside Chiropractic Clinic whose details are listed as above. If you have any questions about this request please contact Dr. Joshua or Dr. Jessica Walker at Tel: (760) 967-7444

____ ___________
Patient Signature Date

____
Patient Print Name