Hall Chiropractic Pain Relief Center

Dr. Robert E. Hall
CHIROPRACTIC PHYSICIAN

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MEDICAL RELEASE AUTHORIZATION

The undersigned hereby authorizes the release of any and all medical information you possess or have access to, pertaining to me, to Dr. Robert Hall, D.C.

I specifically authorize the release to Dr. Robert Hall of any and all medical information, reports, x-rays, statements or bills, information or data which you possess which relates in any way to my health, physical or mental condition.

I hereby expressly waive all privilege which might otherwise attach to any communication or disclosures.

Patient Name (print): _____ Date of Birth: _____

Patient Signature: _____ Today's Date: _____

Please fax all records and reports to:

☐ **Griffith, Indiana Office - (219) 924-2113**
☐ **Merrillville, Indiana Office – (219) 838-3828**