

Acu-Chiropractic Wellness Center, P.A.

4590 Scott Trail Suite 110
Eagan, MN 55122
(651) 454-1000
Fax (651) 454-4375

Patient's Authorization to Release Medical Information

To: _____ Date: _____

Attn: _____

Patient's Name: _____

Address: _____

Social Security #: _____ D.O.B. ____/____/____

Please Send/Fax:

- Complete Medical Records
- Radiology Report(s)
- Other: _____

“ I hereby authorize Acu-Chiropractic Wellness Center, P.A. permission to attain my medical records.”

Patient's Signature: _____

Thank you in advance for your prompt response.

Scott D. Sammon, D.C.
Casey C. Smith, D.C.
Laura E. Frerich, D.C.
Jennifer A. Schulz, D.C.