McCARRIN CHIROPRACTIC CENTER
DR. JOHN E. McCARRIN

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION:

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT INCLUDING THE HISTORY OBTAINED, X-RAY, AND PHYSICAL FINDINGS, DIAGNOSIS, AND PROGNOSIS.

NAME_____ DATE_____

SOCIAL SECURITY NUMBER_____

SIGNATURE_____
(PLEASE SIGN TO AVOID DELAYS IN PROCESSING YOUR CLAIM)