# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, request the release of
(print name)

_____ x-rays including x-ray report

_____ all medical records

_____ other (please specify) _____

_____

I release Dr. Steven P. Kraskow, D.C. from any and all claims resulting from this release.

Please send these records to: _____doctor/clinic name

_____address

_____

_____ phone

_____ _____
(patient signature) (date)

_____
(patient SS#)