Kingston West Family Chiropractic
dedicated to excellence in natural family health
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Authorization to Request X-Rays/Records

I, _____ authorize Kingston West Family Chiropractic to request any radiographs, information or reports concerning my health from:

Name of Doctor/Hospital/Laboratory:_____

_____

Address: _____

_____

Telephone: _____

Fax: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Note: Patients under the age of 18 require authorization by a parent or guardian.

Parent/Guardian Signature: _____ Date: _____

Patient: _____

Date of Birth: _____