WE'VE GOT YOUR BACK

Zelm

CHIROPRACTIC CENTER, S.C.

# Authorization For Release of Medical Records

Fill top portion out if requesting records be sent to us

I hereby authorize _____to release my x-rays and/or reports.
Please transfer records to: (circle which location)

Zelm Chiropractic Center, S.C.

4861 Larson Beach Rd
McFarland, WI 53558
Ph: 608-838-7723
Fax: 608-838-6379

798 Hwy 51
Stoughton, WI 53558
Ph: 608-873-8113

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Fill bottom portion out if requesting we send records to another provider

I hereby authorize Zelm Chiropractic Center, S.C. to release my x-rays and/or reports. Please transfer records to:

Doctor/Clinic:_____

Address:_____

City: _____ State: _____ Zip: _____

Print Name of Patient:_____DOB: _____

Patient Signature:_____Date: _____