Alan Frandsen, DC

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: Date of Birth: [DOB]

SSN:

Last Office Visit:

I request and authorize release healthcare information of the patient named above to & from:

From: Breathe Chiropractic
1130 E. Missouri #402
Phoenix, AZ 85014

To:

This request and authorization apply to:

- ○ Healthcare information relating to the following treatment, condition, or dates
- ◉ All healthcare information
- ○ Other

Travel card information, semg scans, Xray, and any history/notes.

Patient Signature: _____ Date signed: 3/3/21

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.