Mitchell Chiropractic
9844 W. Yearling Rd. Suite D-100
Peoria, AZ 85383

Dr. Scott Mitchell, D.C.
Phone: 623-878-8200
Fax: 623 -878-1200

Medical Release Form

I, the undersigned, hereby authorize Mitchell Chiropractic to release copies of medical records on:

Medical Information to be Released From:

Patient Name: ____

Address: ____

Phone: ____

DOB: ____

Primary Care Office Name: ______________________________________

Primary Care Address: ______________________________________

Primary Care Phone: ______________________________________

Medical Information Releasing To:

Company Name: **Mitchell Chiropractic**

Address: **9844 W. Yearling Rd. Suite D-1100 Peoria, AZ 85383**

Phone: **623-878-8200**

I understand that by signing this medical release form, all of my records pertaining to this particular injury or situation, will be released to a third party to (1) further treat my condition, (2) for further review by the insurance company at the end of treatment, and/or (3) to refer to another physician/specialist.

____

Patient's Signature: Date: