AUTHORIZATION FOR RELEASE OF RECORDS

To: ____

Doctor or Hospital

Address: ____

____

I hereby authorize and request you to release to:

Dr. Molly Keefe
128 North Main Street
St. Albans, VT 05478
802-527-2225(BACK)

any and all health records in your possession, including x-rays, concerning the undersigned.

Date:________________

Witness: __________________________
Relationship: Chiropractic Assistant

Signed: ___________________________

ACAForml6