

OLD MILL CHIROPRACTIC

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AUTHORIZATION FOR RELEASE OF RECORDS

Date: _____

I hereby authorize the release of my _____
or copies of such and request that they be transferred to:

Daniel L. Coogan, D.C.
235 Jungermann Rd., Suite 209
St. Peters, MO 63376
Phone: (636) 928-7387
Fax: (636) 928-1269

Print Name of Patient

Date of Records

Patient Signature

Patient Date of Birth

ATTENDING DOCTOR OR FACILITY

Doctor or Facility Name

Address

City/State/Zip

Phone

Fax