



182 S. MAIN ST. MILPITAS, CA 95035
PH: 408.262.7000 FAX: 408.262.7002

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO: _____

ADDRESS: _____

I, _____ request the following information:

X-rays History Records Diagnosis Treatment Reports Billings
concerning my: Accident Injury Illness Other _____

To be released to: **HEALTHWORKS CHIROPRACTIC**
182 S. MAIN ST.
MILPITAS, CA 95035
Ph: 408.262.7000 Fax: 408.262.7002

For the purpose of: _____

According to Section 123.110 of The California Health & Safety Code, these records/films must be provided within 15 days of your receipt of this notice.

Signed: _____ Date: _____

Patient Spouse Parent Guardian
