



# Anderson Chiropractic

Susan A. Anderson, D.C.

1395 Jordan St., Suite D

North Liberty, IA 52317

## RECORD RELEASE/REQUEST

To \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I hereby authorize the release of my

- X-Rays and report
- Medical Records
- Other \_\_\_\_\_

or copies of such  
and request that they be transferred to:

Anderson Chiropractic  
Susan A. Anderson D.C.

Patient \_\_\_\_\_  
From \_\_\_\_\_ to \_\_\_\_\_  
Patient Signature \_\_\_\_\_  
Date \_\_\_\_\_