GREAT FALLS CHIROPRACTIC CLINIC

Mark T. Stoebe, DC, DABCO
Michael J. Matury, DC

400 13th Avenue South, Suite 104
Great Falls, MT 59405
Phone: 406.727.1660
Fax: 406.452.9094

MEDICAL RECORDS RELEASE

****Please note there is a $15 records Administrative Fee plus $0.50 cents per page. No per-page fee if sent electronically.****

Patient's name: _____
Patient's Date of Birth: _____
Patient's Social Security #: _____
Check appropriate box:

- □ All medical records
- □ Specific Dates: from ____ / ____ / ____ to ____ / ____ /____

I give my permission for the Great Falls Chiropractic Clinic to release my medical records

To: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (___) _____ Fax: (___) _____

These records are to be released for the following purpose:

___ Attorney requests records

___ AFLAC

___Want copies for myself

___I am moving and establishing care with new provider

___Other:_____

_____ _____
Signature Date

_____
Signature of Parent or Guardian

**********This release will remain in effect for one year unless revoked by patient**********