AUTHORIZATION TO RELEASE X-RAYS AND HEALTH INFORMATION

To: _____

_____

_____

I, _____ , request the following information,

XRAYS FILMS TREATMENT NOTES

DIAGNOSIS REPORTS ONLY (XRAY, MRI, LABS, NCV)

be released to:

Dr. Donald G. Ajlouni, D.C.
4986 Cherry Avenue
San Jose, CA 95118
Phone (408) 224-8616, Fax (408) 224-8617

I understand that I have a right to receive a copy of this authorization upon request.

Signature: _____ Date:_____

Patient ID#: _____ DOB: _____