

Health and Medical Information Release Form

I, _____, give permission to Dr. Ryan Shank and staff at Shank Chiropractic Clinic to share medical information with my medical doctor, _____, as well as his staff. Also, my medical doctor and staff have permission to share medical information with Dr. Shank and his staff.

Signature: _____ Date: _____

Patient Information

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Date of Birth: _____

Medical Doctor Information

Name of Doctor: _____

Address: _____

City, State, Zip Code: _____

Phone: _____