Records Release Authorization

TO____

Doctor or Hospital

____

Address

I hereby authorize and request you to release my information to:

Dr. Steven C. Rosa D.C.
1177 Wolcott St.
Waterbury, CT 06705

(203) 573-0011 (Phone)
(203) 597-1809 (Fax)

The complete history records in your possession concerning my illness and/or treatment during the period from_____________ to _____________.

Name____

Date of Birth ___/____/_______ Social Soc. # ______-_____-_______

Address____

Signature____Date________________

If relative, state relationship

Witness____

This form authorizes us to gather your prior medical information