



FAMILY CHIROPRACTIC CENTER, INC.  
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RELEASE FORM

Date: \_\_\_\_\_

I \_\_\_\_\_ give my consent for release of my medical records on this \_\_\_\_\_ day of \_\_\_\_\_ (month) in the year of 20\_\_\_\_.

Signed: \_\_\_\_\_

Witness: \_\_\_\_\_