

**RECORDS RELEASE/REQUEST**

TO \_\_\_\_\_  
(Doctor/Hospital)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I hereby authorize the release of my \_\_\_\_\_

Or copies of such and request that they are transferred to/from:

**SHARP CHIROPRACTIC**  
**4622 COUNTRY CLUB RD. STE 140**  
**WINSTON SALEM, NC 27104**  
**PH# (336) 768-7227**  
**FAX# (336) 768-3802**

\_\_\_\_\_  
Print name of Patient Date

\_\_\_\_\_  
Patient's Signature