

Halle Chiropractic, LLC  
1857 N. Kolb Rd  
Tucson, AZ 85715  
PH: 520-290-2229  
Fax: 520-290-2236

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

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize the release of my X-rays and/or copies of all records and request that they are transferred to:

\_\_\_\_\_  
\_\_\_\_\_

C/O Halle Chiropractic, LLC  
1857 N Kolb Rd  
Tucson, AZ 85715  
Ph: 520-290-2229  
Fax: 520-290-2236

\_\_\_\_\_  
Patient Name ( Please print)

DOB:

\_\_\_\_\_  
Patient Signature

