

# MEDICAL AUTHORIZATION

TO: [name of physician or other health care provider]

[PATIENT I.D. NO.: *if any*]

DATE OF BIRTH:

SOCIAL SECURITY NO.:

I, [patient name], of [address], do hereby authorize you to release to [name of chiropractor / physiotherapist / etc.] any and all information that may be requested pertaining to my physical and/or mental condition, including, but not limited to:

- (i) all records, reports, progress notes, and reports of diagnostic tests;
- (ii) all x-rays;
- (iii) all medical and/or legal opinions with respect to [the patient's] injuries sustained from an accident (including a detailed description of the accident); and
- (iv) any other knowledge or information you possess with respect to the

**SAMPLE PREVIEW**

For doing so, I grant you good and sufficient authority. I hereby authorize that a photocopy of this authorization shall be considered and construed in all respects as the original. I further acknowledge that this authorization shall be effective for up to \_\_\_\_\_ [months / years] from the date of signing.

Dated at \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Witness

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

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address