

**AUTHORIZATION
TO RELEASE MEDICAL INFORMATION**

To: (Provider) _____

Address: _____

Phone: _____ **Fax:** _____

Patient Name: _____ **Birthdate:** _____

I am requesting the following information:

- X-ray Films
- Reports
- Records
- History/Diagnosis
- Treatment
- Reports
- Billings

Concerning any treatment rendered in your office/facility be released/mailed to:

Mooney Chiropractic
Joey L. Mooney, D.C.
26534 Moulton Parkway; Suite C
Laguna Hills, CA 92653

Phone: 949-448-9216; Fax: 949-448-9210

For the purpose of review.

According to Section 123110 of The California Health & Safety Code, these records/films must be provided within 15 days of receipt of this notice.

Signed: _____ **Date:** _____

- Patient
- Spouse
- Parent
- Guardian

Thank You