

COSTANZO CHIROPRACTIC
George J. Costanzo, D.C.
340 North Main St.
Southington, CT 06489
(860) 621-0131

MEDICAL RECORDS RELEASE

To: _____

Address: _____

I, hereby authorize and request you to release to:
Costanzo Chiropractic
340 North Main St.
Southington, CT 06489
(860) 621-0131

The complete history records and/or x-rays in your possession, concerning my illness
and/or treatment during the period from

_____ to _____

Patient's Name _____ Date _____

Address _____

Signature _____
(if relative, state relationship)

Witness _____
