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RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize the release of information, including medical/psychological/physical therapy records, between the following providers:

1. Primary Care and Chiropractic Center (Chad R. Kesner, D.C. and/or Kimberly C. Kesner)
2. _____

Dates Covered:

- All rendered care at this facility or by this provider.
- From ____/____/____ to ____/____/____

Information Released:

- Work-related Injury
- Automobile Injury
- X-rays Films
- X-ray Reports
- Patient Treatment Notes
- MRI Films
- MRI Reports
- Other: _____

This authorization will be in effect unless otherwise notified.

Patient's Signature: _____ Date: _____

If under age 18, Guardian Signature: _____

Witness: _____