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**PATIENT REQUEST FOR RECORDS RELEASE**

To: \_\_\_\_\_  
Doctor/Hospital

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I hereby authorize the release of my records listed below to Dr. Otto Krueger and Krueger Chiropractic.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

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

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

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_