Pequannock Chiropractic Group
Dr. Ian Fliss
Chiropractic Physician

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RELEASE OF MEDICAL INFORMATION AUTHORIZATION

I _____ hereby authorize Dr. Ian Fliss and/or Dr. Robert J. Reinhardt to have access to, or receive a copy of, medical test results that are deemed necessary and important to render safe and effective care to me.

I authorize that this information may be mailed and/or faxed to, Dr. Fliss and/or Dr. Reinhardt, whichever is most appropriate.

I also give consent to fax or mail any information regarding my treatment at Pequannock Chiropractic Group to individuals or groups which I have authorized.

On occasion, our office will find it necessary to contact you with test results. Do we have permission to leave a message with someone other than yourself (husband, wife, parent, etc), or a message on your machine?

[ ] **YES – you have my permission to leave a message with:**
(Husband) (Wife) (Parent) (Other) (Phone Message)

[ ] **Discuss results only with me**

SIGNATURE:_____ _____

DATE: _____

WITNESS: _____