

**Patient's Authorization for  
Release of Medical Records**

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

Date of Request: \_\_\_\_\_

I hereby authorize complete records regarding my treatment by Dr. Dennis J. Gesualdi, D.C. and ChiroCare Plus for the following dates:

From: \_\_\_\_\_ To: \_\_\_\_\_

These records are to be released only to the individual(s) listed below:

Name: \_\_\_\_\_

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

\_\_\_\_\_

Name: \_\_\_\_\_

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

\_\_\_\_\_

This authorization expires on: \_\_\_\_\_, and is not valid for any party not listed above.

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