AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date: _____

TO: _____

_____

_____

_____

You are hereby authorized and requested to furnish to:

Dr. Glenn Lowenberg
Dr. Jeffrey Tirsch
Doctor of Chiropractic
6400 Canoga Avenue, Suite 333
Woodland Hills, CA 91367
(818) 703-8480 Fax (818) 703-9125
e-mail DrGLowenberg@aol.com

any and all medical information, history, records, and diagnoses, reports or x-rays in your possession that are concerning the undersigned.

_____ Date of Birth: _____
Signature

_____ SS#: ____/____/____
Printed Name:

REQUESTMEDRETLC0507