

Kakleas Chiropractic Inc.

We feel that it is very important that we be able to coordinate with your doctors and, as needed, keep them up to date on your treatment and progress here at our office. Please fill in any and all information.

General Physician:	
Address:	
City, State, Zip:	
Phone Number:	

OB Gynecologist:	
Address:	
City, State, Zip:	
Phone Number:	

Podiatrist:	
Address:	
City, State, Zip:	
Phone Number:	

Dentist:	
Address:	
City, State, Zip:	
Phone Number:	

Other:	
Address:	
City, State, Zip:	
Phone Number:	

I give authorization to Kakleas Chiropractic Inc to release my health care information to the above doctors.

Print name: _____ Date: _____

Sign name: _____