

Health and Medical Information Release Form

I, _____, give permission to Dr. Craig Ditzler D.C., his staff, associates, and employees of Ditzler Chiropractic to share private and medical information with my medical doctor, _____, as well as his or her staff, employees, and associates. Also, my medical doctor, as well as his or her staff, employees, and associates have permission to share personal and medical information with Dr. Ditzler and his staff.

Signature: _____ Date: _____

Patient Info

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Date of Birth: _____

Medical Doctor Info

Name of Doctor: _____

Address: _____

City, State, Zip: _____

Phone: _____