General Release

Stucky Chiropractic Center
2105 E Clairemont Avenue, Eau Claire, WI 54701
Phone (715) 835-9514 Fax (715) 835-2602

Date: _____

Date of Birth: _____

I, _____ have requested the release of:

☐ **X-rays**

☐ **Medical Records**

that are a part of the office records of Stucky Chiropractic Center, S.C., relating to my case, and herby acknowledge receipt of these films and medical records. In consideration of the foregoing, I hereby release and forever discharge the aforesaid Stucky Chiropractic Center, S.C. from any and all liability of any kind, nature or character whatsoever from the beginning of the world to this day.

This transaction is consummated at my specific request.

I am requesting that my x-rays/records be sent to:

_____

_____

_____

_____ _____

Patient Signature **Date**

_____ _____

Witness Signature **Date**