ODLAND
Chiropractic Clinic, P.C.

Dr. Rick Odland

X-RAYS OR RECORDS RELEASE

Date _____

To_____

Address _____

City _____ State _____ Zip _____

I hereby authorize the release of my _____ or copies of such and request that they be transferred to:

Dr. Rick Odland
3600 S. Marion Rd.
Sioux Falls, SD 57106

_____	_____	_____
Print Patient's Name	Date of Records	Patient's Signature

D.O.B. _____/_____/_____

SS# _____