JERRY E. DAY, DC, CCSP, PC
Park West Chiropractic & Rehabilitation Center

2750 William D. Tate Ave., #200
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Health and Medical Information Release Form

I, ______________________________, give permission to Dr. Jerry Day, his staff, associates and employees of Park West Chiropractic & Rehabilitation Center to share private and medical information with my medical doctor, _________________________________, as well as his/her staff, employees and associates. Also, my medical doctor, as well as his/her staff, employees and associates have permission to share personal and medical information with Dr. Jerry Day and his staff, associates and employees.

Signature: ____ Date: ____________________

Patient Information

Name: ____

Address: ____

City, State, Zip Code: ____

Phone: ____________________________________ Date of Birth: __________________

Medical Doctor Information

Name of Doctor: ____

Address: ____

City, State, Zip Code: ____

Phone: ____