

PATIENT INFORMATION RELEASE FORM

NOTE: Form to be completed by parent or legal guardian of a patient if that patient is under the legal age of consent.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_ (PRINT PATIENT'S FULL NAME) (DATE OF BIRTH)

give \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ permission to release / discuss (PREVIOUS HEALTH CLINIC)

my relevant healthcare information to / with Moorooka Chiropractic.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_/ \_\_\_\_\_/ \_\_\_\_

**Moorooka Chiropractic Centre**

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