Michael H. Rogers, D.C., D.A.B.C.O.
475 School Street, #7
Marshfield, MA 02050
781-826-6311
Fax: 781-826-6634
www.michaelrogersdc.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize ____ to give all my medical information including laboratory findings, consultation notes, office notes, radiographic reports or other diagnostic imaging reports, actual films or copies of the originals, and treatment plans. Copies of this material will be sufficient. If there is a fee for copying these records, I agree that I am responsible for said fee.

A faxed copy or a photographic copy of this authorization shall serve in it's stead and will continue to remain valid until such time as it is revoked in writing.

The records requested are to be mailed or faxed to Dr. Michael H Rogers.

Name of Patient: ____________________________________

Date of Birth: ______________________________________

Signature of Patient: ______________________________ Date: _________

Thank you for your cooperation. If there are any questions regarding this request, please call the office at (781) 826-6311.