

***Rejuvenations* Chiropractic Care Center**

Dr. Ronald M. Repice, II *Chiropractic Neurologist*

1715 Heritage Trail * Suite 203 Naples FL 34112

239-530-3040 * Fax 239-530-3050

Records Release / Request

To: _____
(Doctor or Hospital)

Address _____

City _____ State _____ Zip Code _____

I hereby authorize and request to release to:

Rejuvenations Chiropractic Care Center

NCH Countryside Commons

1715 Heritage Trail * Suite 203

Naples, FL 34112

239-598-3049 * Fax 239-598-3050

The complete history records in your possession, concerning my illness and/ or

Treatment during the period from: _____ to: _____

Print Name of Patient

Patients Signature

Date

Patients date of Birth

Social Security #