Health and Medical Information Release Form

I, _____, give permission to Dr. Timothy L. Smykal, DC, his staff,
(Patient Name)

employees and associates of the Chiropractic Care Center, LLC., to share private and medical information with my medical doctor, _____, as well as
(Medical Doctor Name)

his or her staff, employees and associates. Also, my medical doctor, as well as his or her staff, employees and associates have permission to share personal and medical information with Dr. Smykal and his staff, employees and associates.

Signature:_____ Date:_____
(Patient/Parent Signature)

Medical Doctor Information

Name of Doctor:_____

Address:_____

City, State, Zip:_____

Telephone Number:_____

Fax Number:_____

Chiropractic Care Center, LLC
N96 W18743 County Line Road, Suite E
Menomonee Falls, WI 53051