

# Holly J. Brown, DOM, L.Ac.

## Medical Records Release Form

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

I hereby authorize: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

to release a copy of my medical records, including x-rays  
and reports to:

Holly J. Brown, LAc, DOM  
% Slocum Chiropractic  
26 Bath Road  
Brunswick, ME 04011  
Fax: 207-725-4222  
Phone: 207-319-7046

Please include the records for the following family members:

Name:	DOB:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature: \_\_\_\_\_

Date: \_\_\_\_\_