# FAIRFIELD FAMILY CHIROPRACTIC, LLC

Douglas A. Torrisi, DC

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## Release of Medical Records

I, the undersigned person, give my consent and authorize you to release the following records or information in your possession to Dr. Douglas Torrisi at Fairfield Chiropractic, LLC.

This authorization releases records from _____ to the present.

Please consider a photostatic copy of this release records to be as effective and valid as the original signed by me.

Signature: _____

Print Name: _____ DATE: _____