Tancredi Chiropractic & Physical Therapy Center

600 Reed Road, Suite 101
Broomall, PA 19008
610-353-9400
FAX 610-353-2280

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

I authorize you to furnish to **Dr. Michael J. Tancredi** of Tancredi Chiropractic and Physical Therapy Center all records relevant to my treatment/care. These documents may include but are not limited to hospital or medical treatment, including diagnostic studies, x-rays, office notes.

This authorization shall be effective for a period of two years from the date it is signed, unless revoked in writing by the undersigned. A copy of this Authorization shall be as valid as the original.

Name:_____

Date of Birth:_____

Social Security No :_____

Signature:_____ **Date:**_____

_____
(PRINT NAME)