

TESTIFIED IN COURT FOR
PLAINTIFF AND DEFENSE
CERTIFIED IN THE RATING
OF PHYSICAL IMPAIRMENT
SECOND OPINIONS
LICENSED TO PERFORM
ACUPUNCTURE

J. Allen Fralicker, D.C.
MEMBER OF THE AMERICAN COLLEGE
OF CHIROPRACTIC ORTHOPEDIST
FRALICKER CHIROPRACTIC CLINIC, INC.
TELEPHONE (904) 745-1444
FAX (904) 743-0805

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Health and Medical Information Release Form

I, _____, give permission to Dr. J. Alien Fralicker, his staff, associates, and employees of Fralicker Chiropractic to share private medical information with my medical doctor, _____, as well as his or her staff, employees, and associates have permission to share personal and medical information with Dr. Fralicker and his staff.

Signature: _____ Date: _____

Patient Information

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Date of Birth: _____

Medical Doctor Information

Name of Doctor: _____

Address: _____

City, State, Zip: _____

Phone: _____