

**RECORDS RELEASE  
PAYMENT AUTHORIZATION**

I, \_\_\_\_\_ AUTHORIZE PAYMENT OF MEDICAL  
BENEFITS TO LAKEPOINT CHIROPRACTIC & MASSAGE CENTER, LLC  
FOR SERVICES RENDERED.

I, \_\_\_\_\_ AUTHORIZE LAKEPOINT CHIROPRACTIC  
AND MASSAGE CENTER, LLC TO RELEASE ANY MEDICAL OR OTHER  
INFORMATION NECESSARY TO PROCESS MY CLAIM TO:

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**Insurance Company Name**

**PRINT PATIENT NAME:** \_\_\_\_\_

**PATIENT/GUARDIAN SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_