Dr Graham Kucan, B.Sc., DC.
Chiropractor
Kucan Chiropractic & Acupuncture Clinic
285-12TH Street, Hanover, ON • 519-364-3020 •
KucanClinic@wightman.ca

Patient Authorization for Exchange of Medical Information

To: Physician: _____

Address: _____

Phone Number: _____

Fax Number: _____

RE: Patient Name: _____

DOB: _____

❒ **I understand that I may refuse to sign this form, and Dr Kucan will still agree to take me on as a patient.**

I hereby direct and authorize you to exchange my medical file and health information with Kucan Chiropractic and Acupuncture Clinic to the attention of Dr. Graham Kucan.

_____ _____

Signature of patient/Guardian Date

_____ _____

Name of patient/ Guardian (please print) Relationship to patient