METCALF CHIROPRACTIC HEALTH CENTER

PO Box 507, 15315 1st Ave NE Suite 5, Duvall, WA 98019 Ph.425-844-6428

Dr. Jeffrey P. Metcalf

RECORDS RELEASE AUTHORIZATION

DATE: _____

TO: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

RE:_____DOB:_____

I hereby authorize the addressee (named above) to release information to:

METCALF CHIROPRACTIC HEALTH CENTER
15315 1ST AVE NE SUITE 5
PO BOX 507
DUVALL, WA 98019

RECORDS: _____ X-RAYS: _____ OTHER: _____

PATIENT SIGNATURE: _____ DATE: _____

Thank you for your time and effort in obtaining these files, and getting them sent out to our office so that we are better able to care for the above stated patient. If you have any questions relating to the above stated release or otherwise, please give our office a call.

Sincerely,

Dr. Jeffrey P. Metcalf