METCALF CHIROPRATIC HEALTH CENTER

15435 Main St NE, Suite 101 PO Box 507 Duvall, WA 98019 ph. 425-844-6428 fax. 425-788-7824

Dr. Jeffrey P. Metcalf

Records Release Authorization

I, _____, authorize the release of my records: *(check one)*

☐ To ☐ From

Metcalf Chiropractic
PO Box 507
Duvall, WA 98019
Ph. (425) 844-6428
Fax (425) 788-7824

☐ To ☐ From

_____
(Provider Name)

_____
(Office Name)

_____
(Address)

_____
(City, State, Zip)

_____
(Phone) (Fax)

☐ X-rays ☐ Records ☐ Other: _____

Patient Name: _____ D.O.B. _____

Patient Signature: _____ Date: _____

This authorization will expire one year from the date signed. If you have any questions relating to the above stated release or otherwise, please give our office a call.

Sincerely,

Dr. Jeffrey P. Metcalf