King George Family Chiropractic

9305 Kings Highway, Suite A

King George, VA 22485

(P) 540-775-2250

(F) 540-775-2448

Dear Dr. _____

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check marks below) or to otherwise release confidential information. At this time I am requesting the following:

_____ Complete Record

_____ Records of care from _____ to _____ only.

_____ Other. Specify: _____.

_____ Confer with other person orally about information in my medical record.

To the following person(s):

_____

Name

_____

_____

Address

The reason or purpose for this release of information are:

_____

_____

I understand that all attempt will be made to provide this information within 21 days of receipt of this request, and you may be changed a fee for preparation and furnishing this information.

Signed: _____ Date: _____

Printed Name: _____ Birth Date: _____

Staff Accepting Form: _____ Date: _____