West Chester Family Chiropractic Center

Authorization for the Release of Medical Records

Name: _____

Address: _____

Phone: (_____) _____ - _____

Date of Birth: _____

Having requested release of my original records, including X-ray(s) if applicable, I hereby acknowledge receipt of all my original records from West Chester Family Chiropractic Center.

Records received:

_____ Treatment Records

_____ X-ray(s)

_____ _____

Signature of Patient Date

OR

_____ _____

Signature of Legal Representative Date

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.