

Pine Tree Chiropractic PC
2515 Crosby Ave
Klamath Falls, OR 97603
541-883-2225
541-882-9388 Fax

Records Release Request

Patient Name _____ Date of Birth _____

Address _____

Release records from: _____

Address City State Zip code

(____) _____ (____) _____

Phone Number Fax Number

_____ chart notes _____ X-ray Report _____ X-ray Films _____ Billing Ledger

_____ Other (please specify) _____

Release records to: _____

Address City State Zip code

(____) _____ (____) _____

Phone Number Fax Number

I authorize Pine Tree Chiropractic PC to release the above information that I have requested to be sent within 30 days from receipt of the released signed date. I am aware there is a minimum \$25.00 charge for obtaining the medical records to be payable when complete.

I give permission to fax the information requested (with the exception of x-rays) by including my initials _____.

Patient Signature

Date

Witness Signature

Date