BLAINE CHIROPRACTIC & MASSAGE

245 H St
Blaine, WA 98230
Phone: 360-332-1086
Fax: 360-332-6071
Email: admin@blainechiropractic.com

Authorization to Release Medical Records

Patient Information

Full Name: _____
Date of Birth (MM/DD/YYYY): ___ / ___ / _____
Phone Number: _____
Email Address: _____

Release Records From

Facility/Doctor Name: _____
Address: _____
City, State ZIP: _____
Phone: _____
Fax: _____

Send Records To

Blaine Chiropractic and Massage
Fax: 360-332-6071
Email: admin@blainechiropractic.com

Purpose of Request

☐ Continuity of Care
☐ Legal
☐ Insurance
☐ Other:
_____

Information to be Released

☐ Complete Medical Records
☐ Imaging (X-rays, MRI, etc.)
☐ Progress Notes
☐ Lab Reports
☐ Billing Information
☐ Other: _____

Authorization Expiration Valid for one year from the date of signature
Patient Authorization and Signature I authorize the release of the above medical records as indicated. I understand that I may revoke this authorization at any time in writing.

Signature: _____
Date: ___ / ___ / _____

For Office Use Only Date Request Sent: ___ / ___ / _____Initials: _____