PATIENT REQUEST FOR RECORDS & XRAYS

To: _____
_____
_____

I hereby authorize the release of my records and x-rays, and request that they be transferred to:

Bothell Chiropractic & Wellness
Dr. Dusty DuBois
10024 Main Street #2C
Bothell, WA 98011
(425) 485-1413
(425) 485-1283 Fax
www.bothellchiropractic.com

PRINT NAME: _____ **DOB:** _____

SIGNATURE: _____ **DATE:** _____

☐ Will pick up records

☐ Please mail or hand deliver to the above address

This release will expire in 1 year from the date of signature.
If you have any questions regarding this request, please call our office.