MONTALAND & MCGRATH CHIROPRACTIC CENTER

REQUEST OF RECORDS

Date:_____

Patient:_____ DOB:_____

To (Doctor, Clinic or Hospital): _____

Address: _____

City: _____State: _____ Zip: _____

Phone:_____ Fax:_____

I hereby authorize the release of my

_____

_____

or copies of such and request that they be transferred to:

Montaland & McGrath Chiropractic Center
Dr. Alexie Montaland, D.C.
or
Dr. Thomas Gentry McGrath, D.C., D.A.C.N.B.

14405 NE 20th Steet
Bellevue, WA 98007
Fax: 425-641-5337 Phone: 425-641-2527

Print Name of Patient_____

Patient's Signature_____