21 West Robert Toombs Avenue
Washington, GA 30673
(706) 678-3292

Request for Release of Records

Name: _____ Acct #: _____

Address: _____ City: _____

State: _____ ZIP: _____

Primary phone: _____

S.S.N.: _____ Birth Date: _____

I hereby request the release of the records of my treatment at:

_____ to:

TOWNSEND CHIROPRACTIC
21W Robert Toombs Ave
Washington, Ga 30673
Phone: 706-678-3292
Fax: 706-678-3147

Reason for records release:

- (●) Independent Medical Examination
- ( ) Second Opinion
- ( ) Patient Moving
- ( ) Other: _____

Patient/Parent/Guardian's Signature: _____Date: _____

Note: *Upon the receipt of your signed authorization, compiling of your records will begin. Depending upon the extent of the file, there may be a charge to provide the records. If there is a charge, you will be notified of the amount and once payment is received on our office, records will be forwarded.*