

Virginia Family Chiropractic & P.T., PLLC

PATIENT RELEASE OF RECORDS

DATE: _____

TO: _____
DOCTOR/HOSPITAL/OTHER FACILITY

I HEREBY AUTHORIZE THE RELEASE OF MY

- X-RAYS/MRI/CAT SCAN REPORTS, dated _____
- FILMS OR DOCUMENTS, dated _____
- ER RECORDS, dated _____
- MEDICAL RECORDS, dated _____

AND REQUEST THAT THEY WILL BE FAXED OR MAILED TO:

Virginia Family Chiropractic & P.T., PLLC

5249 Duke Street
Suite 205
Alexandria, VA 22304
Phone: (703) 370-5300
Fax: (703)370-0080

14904 Jefferson Davis Hwy
Suite 301
Woodbridge, VA 22191
Phone: (703) 499-8840
Fax: (703) 499-8842

8420 Dorsey Circle
Suite 101
Manassas, VA 20110
Phone: (703) 367-7878
Fax: (703) 367-0009

150 Little Falls Street
Suite 205
Falls Church VA 22046
Phone: (703) 538-3830
Fax: (703) 538-3831

Patient's Name: _____

Patient's Date of Birth: _____

Patient's Social Security Number: _____

PATIENT'S SIGNATURE

This release shall be effective for a term of not less than five (5) years from the date of the execution.