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PATIENT REQUEST FOR RECORDS & XRAYS

To:

From:

Mukilteo Chiropractic Clinic
Dr. Steve Kreutz
8004 Mukilteo Speedway, Suite 1
Mukilteo, WA 98275

I hereby authorize the release of my records as specified below:

- Complete medical records (all notes, x-rays and billing information)
- X-rays and/or Diagnostic Images
- Other: _____

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

_____ Will pick up records

_____ Please send 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.