FAMILY FIRST CHIROPRACTIC

Dr. Christine Lebiecki ♦ Dr. Courtney Peet

Patient Records Release

Patient Name _____ Date of Birth _____

Patient Mailing Address: _____

❑ This authorizes

Name _____ Phone _____

Address _____ Fax _____

to release a copy of my patient records regarding any analysis, diagnosis, treatment, and/or condition via mail or fax to Family First Chiropractic, 525 Hercules Drive, Suite 1B, Colchester, VT 05446 Phone: (802) 860-0382 Fax: (802) 655-0154; including but not limited:

- ____ Chiropractic office notes
- ____ Hospital and physician office records
- ____ X-ray reports, MRI, CAT scan reports
- ____ Physician office records only
- ____ X-rays/copies of X-rays (please send actual X-rays not just a report)

❑ This authorizes Family First Chiropractic to release a copy of my patient records to:

Name _____ Phone _____

Address _____ Fax _____

regarding any analysis, diagnosis, treatment, and/or condition, including but not limited to:

- ____ Chiropractic office notes
- ____ Hospital and physician office records
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- ____ Physician office records only
- ____ X-rays/copies of X-rays (please send actual X-rays not just a report)

_____ Date_____

Signature of patient; patient's legal guardian; or personal representative.

Relationship to patient _____

Thank You!