

## CHIROPRACTIC RECORD REQUEST FORM

| Patient's Name:                            |  |
|--|--|
| Address:                                   |  |
| DOB:                                       |  |
| Irelease a copy of my chiropractic record. | _ authorize Chiropractic Center of Georgetown to |
| ☐ Transferred to:                          |  |
|  |  |
| ☐ Will pick up in person.                  |  |
|  |  |
| Patient's Signature:                       |  |
| Date:                                      |  |