

RECORDS RELEASE

TO:

Bellevue Chiropractic Associates
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Laurin McElheran, DC
Brock Barnick, DC
Jason Silliker, DC

I hereby authorize the release of my: ☒ X-RAYS ☒ RECORDS

Or copies of such and request they be transferred to:

Myself

<input type="text"/>	<input type="text"/>
Patient Name	Date of Birth
<input type="text"/>	<input type="text"/>
Patient or Legal Guardian Signature	Date