CHIROPRACTIC WELLNESS CENTER
9689 Main Street, Suite B
Fairfax, VA 22031
(703) 323-0068

(PLEASE PRINT)

Records Release Authorization

Patient's Name: ____

Social Security Number: ____

Date of Birth: ____

Patient Signature: ____

Date: ____

To: ____

____

____

Attention: **Dr. Eric Chu**

I, above name patient, authorize and direct you to release any and all medical records, x-rays or any other information in your possession concerning my care / treatment to:

Chiropractic Wellness Center
9689 Main Street,
Suite B,
Fairfax, VA 22031
(703) 323-0068

All records received by Chiropractic Wellness Center are used only to coordinate and plan care of patient.