Records Release Request

Date: _____

To: _____
Hospital/Clinic/Physician

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Patient Name: _____ DOB: _____

Requesting Images: _____

- Please mail the disc and fax the report

I authorize the release of my medical records from _____ to _____
And request that they be transferred to:

GRANDE RONDE CHIROPRACTIC CLINIC LLC
DR. CASEY A. MCKEOWN DC, DACBSP
1108 J Avenue
La Grande, OR 97850
Phone: (541)963-0339
Fax: (541)663-8882

Print name of patient

Signature (patient, parent, guardian)