

MONTALAND MCGRATH CHIROPRACTIC
REQUEST OF RECORDS

Date: _____ Patient: _____

To (Doctor, Clinic or Hospital): _____

Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize the release of my _____ or copies of such and request that they be transferred to:

Dr. Alexie Montaland, D.C. or Dr. Thomas Gentry McGrath, D.C., D.A.C.N.B.
2005 152nd Avenue N.E.
Redmond, WA 98052

Print Name of Patient

Patient's Signature