Bourree Chiropractic and Massage

Release of Records

Date: _____

To: _____

I, _____, hereby request the above- named to release copies or all pertinent medical records and records and x-ray films to Bourree Chiropractic and Massage, David Bourree, DC DACS as of the above date. These records may be sent directly to the doctor/clinic, or given to me personally.

Printed Name: _____

Signed: _____
(Patient and/or Patient's Representative)

Date of Signature: _____

Records to be sent to:
David Bourree DC, DCAS
12841 NE 85th ST
Kirkland, WA 98033
ATTN: David Bourree

Original records and x-ray films will be returned when they have served their purpose. Thank you for your cooperation.

Phone: 425-827-0334 Fax: 425-284-6884