RELEASE OF MEDICAL RECORDS

I, ________________________________ hereby request the release of my original records, or copies thereof, to:

Kevin McClain, DC
2640 N. Hwy 67
Florissant, MO 63033
(314) 838-6083
FAX: (314) 838-8994

Hospital/Doctor/Imaging: _________________________

Please include the following in the request:

{ } Emergency department records
{ } Doctor's office records
{ } Radiographs and report [MRI] [X-rays]
{ } Other pertinent information ___________

Patient name: _________________ Age: _______

Social Security #: ______________ DOB: ___________

Date(s) of office/emergency dept. visits:______________

Patient signature: ____________________Date: _______