Patient Records Release

I _____, hereby authorize the release of any and all my records relating to my care, including any radiological studies, to Alpine Wellness Clinic, PC.

May this signed consent form be your good authority to do so.

***Patient Signature*: _____ *Date:* _____**

My records are currently located in the good hands of:

Doctor: _____

Clinic: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

Please Send the Following Records ASAP:

- ❑ X-Rays and Reports
- ❑ Plan of Management
- ❑ Treatment Notes
- ❑ Blood Work
- ❑ Other: _____

Address to be sent to:

Alpine Wellness Clinic, P.C.

Alpine Wellness Chiropractic

16205 West 64th Avenue, Suite B-1

Arvada, Colorado 80007

Office: (303) 431-8588 Fax: (303) 431-9232

Thank You!