RECORDS RELEASE AUTHORIZATION

I authorize the release of all my
Medical Records / X-rays – to/from:

____

____

____

____

To be released to/from:

Emerald City Spinal Care
1222 E Madison Street, Suite D
Seattle, WA 98122
206.204.8255 Phone
206.204.8259 Fax

Name____________________________ DOB_________
Address____
Signature_________________________ Date_________