



Authorization to Release Information

I _____, hereby request the release of my x-rays / records to be sent to:

Advanced Sports Chiropractic
2101 Cornwall Ave. #102
Bellingham, WA 98225
(360) 647-1900
Fax (360) 647-1542

Patient or legal representative signature _____ Date _____

Dr. Signature _____ Date _____

360-647-1900

*Advanced Sports Chiropractic, 2101 Cornwall Ave, #102, Bellingham, WA 98225
Monday 8am-6pm, Wednesday/Thursday 8am-5:30pm, Friday 7:30am-11:30am
www.advancedsportschiropractic.com*