Verve Chiropractic, PLLC

Record Release Form

Lauren Scott, D.C.

Patient Name:_____

Patient DOB:_____

Practice to Release Records:_____

Doctor to Release Records:_____

Address of Practice:_____

City:_____ State:_____ Zip:_____

Phone Number of Practice:_____

Fax:_____

I hereby authorize and request the release the medical records of _____ to:

Dr. Lauren Scott
Verve Chiropractic PLLC
5530-111 Munford Rd
Raleigh, NC 27612

_____ _____
Patient Signature Date

_____ _____
Signature of Guardian (if minor) Date

_____
Relationship to Patient

_____ _____
Witness to Signatures Above Date

_____
Printed Name of Witness