DUDKO CHIROPRACTIC, LLC
Dr. Suzanne Dudko

AUTHORIZATION FOR RELEASE OF RECORDS

Date_____

To_____
_____
_____

Additional information has been requested by Dudko Chiropractic, LLC which is needed for proper diagnosis of my condition, so I hereby authorize the release of my x-rays, reports and records to be transferred to:

Dudko Chiropractic, LLC
9010 Lorton Station Blvd., Ste. 110
Lorton, VA 22079
(703) 436-2207 ext. 801 Office
(703) 879-3484 Fax
Attn: Patient Records

Patient's Name_____

Patient's Date of Birth_____

Patient's Signature_____

Doctor's Signature_____