



Crabtree Chiropractic Center

Dr. Marc A. Burr
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Date: _____

I, _____, do hereby request that _____ send out:

___ X-rays

___ Office Notes

___ My record from (Dates of Service) _____ to _____

___ My record in its entirety

To: _____

This request is being made for:

___ Processing Insurance Claims (Auto or Health)

___ Second Opinion

___ My personal record

___ Other: _____

I, _____, realize that there may be a charge for such information to be released and that I will be informed of such charge and held accountable for the charge before any records will be sent out.

Printed Patient Name

Patient Signature

Today's Date

W:Forms/Request records



Therapeutic Massage

Debbie Ankhelyi
919-696-7400

Mary Seitz Bridges
919-539-6798

By Appointment only