REQUEST FOR MEDICAL RECORDS

Patient Information

Patient Name: _____ DOB: _____

File #: _____ Date of Request: _____

Please Release Records From:

Clinic Name: _____

Doctor Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____

Send the Following Records/Reports/Films:

- ❑ Medical/Chiropractic Records (Recent records only) Do not include billing records.
- ❑ Medical/Chiropractic Records (All past records) Do not include billing records.
- ❑ X-ray report and films_____
- ❑ MRI Report/Films
- ❑ CT Report/Films
- ❑ EMG, SSEP, and Nerve Conduction Study Reports
- ❑ IME Report
- ❑ Other_____

Please Send Records to:

Amarillo South Chiropractic and Physical Therapy
2828 Wolflin Ave
Amarillo, TX 79109
806 322-1663 Office
806 322-1665 Fax

I, (Patient Name)_____, hereby request and authorize the above records and tests to be released and mailed to the doctor/facility indicated in this form. It is understood that any X-ray, CT, or MRI original films will be returned to the originatitng facility within 30 days after receiving them.

Signature of Patient:_____