

PATIENT REQUEST FOR RECORDS

DATE: ____ / ____ / ____

PATIENT: _____ ACCT#: _____

DATE OF BIRTH: ____ / ____ / ____ SSN: ____ - ____ - ____

DATE OF RECORDS: _____

These records are needed immediately in order to properly process this patient. You would greatly assist us if you would:

- Radiology Reports (X-rays, MRI, CT)
Films in question: _____
- Actual film copies of x-rays / MRI's / CT's (by mail).
- Office Notes and Dictations
- Emergency Room Records / Lab Reports / Diagnostic Studies
- Ambulance Transporter's Report
- Special Studies (i.e. NCV, EMG, etc.)
- Surgical / Post-Surgical Reports
- Other: _____

I HEREBY AUTHORIZE THE RELEASE OF MY X-RAYS / RECORDS AND REQUEST THAT THEY BE TRANSFERRED TO:

Sheppard Chiropractic
1238 W. Ohio Pike
Amelia, OH 45102
Phone: 513-753-5437 Fax: 513-753-7517

PATIENT SIGNATURE: _____

DATE: ____ / ____ / ____

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