Wake Forest Chiropractic

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PATIENT RECORDS REQUEST & RELEASE

Requested from: ______________________________

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❒ I request that you release my records indicated below to Wake Forest Chiropractic via fax or mail to the above fax/address.

❒ I give my consent to release my records indicated below to the above fax/address.

Please send: ❒ X-rays ❒ History ❒ Treatment Notes ❒ Reports

Printed patient name: ______________________________

DOB: ____________________

For the purpose of:

❒ Treatment ❒ Evaluation

______________________ ____________

Patient signature Date

Thank you in advance for your cooperation.

Intended for the use of the addressed individual and contains privileged, confidential information. If the reader is not the intended recipient, any distribution or copying is prohibited by law. If you have received this communication in error, please notify us immediately by telephone and return the original document to the above address via US Postal Service. Thank You.