**PATIENT REQUEST FOR RECORDS**

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| Date: |  |  |  |
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| To: |  |
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| Voice: |  | Fax: |  |
| Email: |  |

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| **I hereby authorize the release of my records, x-rays, MRIs and other diagnostic tests or copies of such to Wellesley Chiropractic Office.** |
|  |  | **SELF PARENT GUARDIAN** |
| Signature of Patient or Personal Representative |  | Description of Personal Representative’s Authority |
|  |  |  |  |
| Patient Name: |  | ID #: |  |
| Date of Birth: |  | Social Security No: |  |
| Date(s) of records: |  |
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| 🞎 | Please fax reports to **781-996-4347** |
|  |  |
| 🞎 | Please mail films to: 🞎 **STAT** |
|  | **Wellesley Chiropractic Office****471 Washington St****Wellesley, MA 02482-5935****(781) 237-6673** |

Records Request (new)