**PATIENT REQUEST FOR RECORDS**

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| Date: |  |  | |  | |
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| To: |  | | | | |
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| Voice: |  | | Fax: | |  |
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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** |
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| 🞎 | Please mail films to: 🞎 **STAT** |
|  | **Wellesley Chiropractic Office**  **471 Washington St**  **Wellesley, MA 02482-5935**  **(781) 237-6673** |

Records Request (new)