PATIENT REQUEST FOR RECORDS

DATE:_____

RECORDS TO BE SENT FROM:

DR DEANNA BARBARO / A BETTER LIFE CHIROPRACTIC **ATTENTION:** RECORDS

(DOCTOR/HOSPITAL)

ADDRESS: 661 GOODLETTE ROAD NORTH UNIT 108

CITY: NAPLES **STATE:** FL **ZIP:** 34116

TEL (239 **)** 263 **-** 3369 **FAX (** 239 **)** 263 **-** 8842

I hereby authorize the release of my _____ or copies of such and request that they are transferred to:

ATTENTION:_____ ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

TEL (___) _____-_____ FAX (___) _____-_____

Email: _____@_____

PATIENT NAME: _____ FILE _____ DOB:_____

_____

PATIENT SIGNATURE