PATIENT REQUEST FOR RECORDS

DATE:_____

RECORDS TO BE SENT FROM:

_____ ATTENTION:_____

(DOCTOR/HOSPITAL)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

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

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

DR DEANNA BARBARO / A BETTER LIFE CHIROPRACTIC

ATTENTION:_____RECORDS_____ **ADDRESS:**_____661 GOODLETTE ROAD NORTH UNIT 108_____

CITY: _____NAPLES_____ **STATE:** _____FL_____ **ZIP:** _____34116_____

TEL (239**)** __263__**-**__3369__ **FAX (**239**)** __263__**-**__8842__

Email: _____ABETTERCHIRO**@**GMAIL.COM_____

PATIENT NAME: _____ FILE _____ DOB:_____

_____

PATIENT SIGNATURE

Please email X-Rays to: abetterchiro@gmail.com