Spees Chiropractic

PATIENT REQUEST FOR RECORDS

PATIENT NAME:____

ADDRESS:____

CITY:____________________ STATE:_________ ZIP: _________

DATE OF BIRTH: ___ / ___ / ___ SSN:____ - ____ - ______

FACILITY OF RECORDS: __________________________________

APPROXIMATE DATE OF RECORDS:_________________________

These records are needed immediately in order to properly process this patient. You would greatly assist us if you would please submit the following necessary records:

- ❑ Radiology Reports (X-rays, MRI, CT)
  Films in question:______________________________
- ❑ Actual film copies of x-rays / MRI's / CT's (by mail).
- ❑ Office Notes and Dictations
- ❑ Emergency Room Records / Lab Reports / Diagnostic Studies
- ❑ Ambulance Transporter's Report
- ❑ Special Studies (i.e. NCV, EMG, etc.)
- ❑ Surgical / Post-Surgical Reports
- ❑ Other:____

I HEREBY AUTHORIZE THE RELEASE OF MY X-RAYS / RECORDS AND REQUEST THAT THEY BE TRANSFERRED TO:

Spees Chiropractic
1633 CELINA RD
Saint Marys, OH 45885
Phone: 419.300.9790 Fax: 419.300.9789

PATIENT SIGNATURE:__________________________ Date:___/___/___

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