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Record Request Form

I, _____ hereby request that

Doctors Name: _____

Address: _____

City, State & Zip: _____

Phone: _____ Fax: _____

Please release and provide a copy of the following:

- _____ All lab tests
- _____ All Cat scans, MRI and X-rays
- _____ All medications/supplements
- _____ All patient progress notes
- _____ All of my complete medical records from the period of _____ to _____
- _____ Other: _____

For the purpose of providing information that may benefit my treatment. I am aware that I may rescind this permission at any time in writing.

Please send my records to:

Doctors Name: _____

Address: _____

City, State & Zip: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____