DOUGLAS CHIROPRACTIC & MEDICAL CENTERS

DMLM 00_REV 7/8/14

# MEDICAL RECORD REQUEST

DATE: _____

PATIENT NAME: _____
CLAIM NUMBER: _____

AS REQUESTED BY YOUR OFFICE, OUR OFFICE HAS MADE COPIES OF THE ABOVE MENTIONED PATIENT'S MEDICAL RECORDS.

TOTAL NUMBER OF PAGES: _____
COST FOR COPYING RECORDS: _____

WOULD YOU BE SO KIND TO FORWARD A CHECK WITHIN ONE WEEK FOR THE ABOVE WRITTEN AMOUNT.

TO: **DOUGLS RAPID REHAB, P.A.**
4140 N.W. 12TH STREET
LAUDERHILL, FL 33331

THANK YOU FOR YOUR ATTENTION TO CHARGES OF COPYING YOUR CLIENTS OUR PATIENT'S FILE.

RESPECTFULLY.

**DOUGLAS RAPID REHAB, P.A.**
TEL: 954.739.3331 FAX: 954.792.4520
RECORDS@DOUGLASCHIROPRACTIC.COM