DOUGLAS CHIROPRACTIC & MEDICAL CENTERS

DMLP 00_REV 7/8/14

PATIENT REQUEST FOR RECORDS

DATE _____

TO _____

(DOCTOR / HOSPITAL)

ADDRESS _____

CITY _____ STATE _____ ZIP _____

I HEREBY AUTHORIZE THE RELEASE OF MY _____

OR COPIES OF SUCH AND REQUEST THAT THEY ARE TRANSFERRED TO:

DOUGLAS RAPID REHAB, P.A.
4140 N.W. 12TH STREET
LAUDERHILL, FL 33331
TEL: 954.739.3331
FAX: 954.792.4520
RECORDS@DOUGLASCHIROPRACTIC.COM

PATIENT NAME _____

SOCIAL SECURITY _____ D.O.B _____

PATIENT SIGNATURE _____

PRINT NAME _____