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 ____