



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.
8910 Miramar Parkway, Ste 115
Miramar, FL 33025
Phone: 954-739-3331
Fax: 954-792-4520
RECORDS@DOUGLASCHIROPRACTIC.COM

PATIENT NAME _____

SOCIAL SECURITY _____ D.O.B _____

PATIENT SIGNATURE _____

PRINT NAME _____