

REQUEST FOR MEDICAL RECORDS

Sands Chiropractic Polk City IA 50226

Patient Information

Patient Name: _____ DOB: _____

File #: _____ Date of Request: _____

Please Release Records From:

Clinic Name: _____

Doctor Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____

Send the Following Records/Reports/Films:

Medical/Chiropractic Records (Recent records only) Do not include billing records.

Medical/Chiropractic Records (All past records) Do not include billing records.

X-ray report and films _____

MRI Report/Films

CT Report/Films

EMG, SSEP, and Nerve Conduction Study Reports

IME Report

Other _____

Please Send Records to:

Sands Clinic of Chiropractic

1010 S 3rd St Ste 2B

Polk City IA 50226-1181

Tel 515-984-6484

Fax 888-873-9489

I, (Patient Name) _____, hereby request and authorize the above records and tests to be released and mailed to the doctor/facility indicated in this form. It is understood that any X-ray, CT, or MRI original films will be returned to the originating facility within 30 days after receiving them.

Signature of Patient: _____