TEMECULA VALLEY CHIROPRACTIC
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Dr. Donald Myren, D.C. & Assoc.

Medical Records Request Form

Patient_____

Address_____

_____

Date of Birth_____ Social Security Number_____

I, the undersigned, hereby authorize and request

_____

(Doctor and/or Hospital)

_____

(Address)

To provide one or more of the following circled

1) Medical Records (History, Exam, Treatment Records, Reports)
2) X-Rays (Films and Reports)
3) MRI/CT Scan (Films and Reports)

in your possession, concerning my illness and/or treatment. During the period of _____ to present, for the purpose of _____.

Release or transfer of the specified information to any person or entity not specified herein is prohibited. An additional written consent must be obtained for a proposed new use of the information or its transfer to another person or entity.

This authorization shall be valid until _____
(Date)

I understand that I have a right to receive a copy of this authorization upon my request.

Copy requested and received: Yes No

_____ _____
(Patient's Signature) (Date)

_____ _____
(Witnesses By) (Date)