

**PATIENT REQUEST FOR X-RAYS AND/OR RECORDS**

To: \_\_\_\_\_

Attn: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I hereby authorize the release of my X-rays and/or records or copies of such and request that they be transferred to:

**Back 'N Balance Chiropractic**  
**Patricia L. Gregg D.C., P.A.**  
**Janis R. Frahm, D.C.**  
**Scott Sweeney, D.C.**  
**Shelley A. Lorenzen, D.C.**  
**1205 Nueces St.**  
**Austin, TX 78701**  
**Ph. (512) 479-7878**  
**Fx: (512) 479-6280**

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Date of Records

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Today's Date