

PATIENT REQUEST FOR X-RAYS AND/OR RECORDS

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

***Back 'N Balance Chiropractic
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Ph. (512) 479-7878
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To: _____

Attn: _____

Street Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Print Name of Patient

Date of Records

Patient's Signature

Today's Date