Medical Records Request Form

I, _____ give permission to release a copy of my personal medical records, summary of treatment or narrative of my protected health information to the entity listed below.

Requesting Records From:

 I authorize _____

_____

_____

_____

Send Records To:
Keith Lavender, DC
[ ] Foresight Chiropractic, PLC

2915 E. Baseline Rd. Ste. 126
Gilbert, AZ 85234
Phone: 480-325-6977
Fax: 602-296-0487

Type of Records Requested:

[ ] Any and All Type of Treatment for this Patient
[ ] Treatment Related to Specific Injury or Illness:_____
[ ] Beginning & Ending Dates of Treatment _____
[ ] X-Rays and Radiology Notes

_____ _____
Patient's Name (print please) Patient or Guardian signature

_____
Patient's date of birth

_____
Date of Request