DRAEGER
CHIROPRACTIC & LASER CENTER

Dr. Lindsy Jaworski, DC

PATIENT REQUEST FOR RECORDS AND AUTHORIZED RELEASE

DATE OF REQUEST: ____________________

Patient Information:

PATIENT NAME: ____

DATE OF BIRTH: ____

ADDRESS: ____

CITY: ____ **STATE:** _________ **ZIP:** ____________________

Requesting records from:

DOCTOR/MEDICAL FACILITY: ____

ADDRESS: ____

CITY: ____ **STATE:** _________ **ZIP:** ____________________

DATE OF RECORDS: ____

ITEMS REQUESTED:
- ☐ X-ray report
- ☐ MRI report
- ☐ CT Scan report
- ☐ X-rays on CD (or film copy)
- ☐ MRI on CD
- ☐ CT Scan on CD
- ☐ Daily chart notes
- ☐ Other_____________________________________

Send records to:

Draeger Chiropractic & Laser Center
Attn: Medical Records
2327 Neva Road
Antigo, WI 54409

By signing this form, I hereby authorize the release and transfer of my medical records and diagnostics, or copies of such.

PATIENT SIGNATURE: X____ **DATE:** ____________