

PATIENT REQUEST FOR RECORDS AND AUTHORIZED RELEASE

DATE OF REQUEST:				
Patient Information	n:			
PATIENT NAME: _				
DATE OF BIRTH: _				
ADDRESS:				
CITY:		STATE:	ZIP:	
Requesting records	s from:			
DOCTOR/MEDICA	L FACILITY:			
ADDRESS:				
			ZIP:	
DATE OF RECORDS	S:			
ITEMS REQUESTED: ☐ X-ray report				
	☐ X-rays on CD (or film copy)	☐ MRI on CD	☐ CT Scan on CD	
	☐ Daily chart notes	☐ Other		
Send records to:				
Joint & Spine Attn: Medical Re 2327 Neva Road Antigo, WI 54409				
By signing this form, I is diagnostics, or copies of	•	elease and transfer of	my medical records and	
PATIENT SIGNATURE: Y			DATF:	

Phone: 715-623-2123