WOLFE FAMILY
CHIROPRACTIC

RECORDS RELEASE REQUEST

Full Legal Name of Patient: _____ **DOB:** _____

Requesting Entity (Doctor or Facility): _____ Date: _____

Mailing Address: _____ Phone Number: _____

_____ Fax Number: _____

Holding Entity (Doctor or Facility): _____

Mailing Address: _____ Phone Number: _____

_____ Fax Number: _____

Records Requested:*

☐ Daily Progress Notes (Date:_____ to _____)

☐ X-ray Images (Please Describe Studies Requested) _____

☐ Accounts and Billing Information

☐ All Records Available

☐ Other: (Please Describe) _____

**Please note that Wolfe Family Chiropractic may assess a reasonable fee to the patient to cover the cost of copying requested records, including x-rays.*

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ Date: _____

830 W. Dryden Rd.
Metamora, MI 48455

Fax: (810) 212-1202
Phone: (810) 212-1200

WolfeFamilyChiro.com
info@wolfefamilychiro.com