Date: _____

RE: Request for records

Name of Doctor: _____
Office Phone Number: _____
Fax Number: _____

Dear Dr. _____,
I authorize the release of my medical records and/or a copy of my x-ray report to be sent to the address below. Thank you very much for your time.

Sincerely,

_____

Printed Name: _____

Date of Birth: _____

Last 4 digits of social security number: _____

Please send to:

Addison Chiropractic Clinic
Madeline Witte Glass, D.C.
4540 Belt Line Road
Addison, TX 75001

(972) 789-9333 office
(972) 789-9557 Fax