LONGNER
Chiropractic

PATIENT REQUEST FORM

Patient Information:

____ ____/____/____
Name of Patient Please Print First/Last Date of Birth(mm/dd/yy)

(______)______________________
Phone Number

____
Street Address

____
City/State/Zip

Released from:

Name/Facility: ____

Address: ____

City/State/Zip: ____

Phone: ______________________ Fax: ______________________

Released to:

LONGNER CHIROPRACTIC
3712 HWY 95 BSTE #8
BULLHEAD CITY, AZ, 86426
PHONE:(928)763-9333 FAX:(928)763-9313

I hereby authorize the release of all my medical records including x-rays or copies of such and request that they are transferred to the medical facility listed above.

____
(Complete Name of Patient) (Date)

____
(Patient's Signature)