

hawthorne chiropractic & healing arts

1222 se division street, portland, oregon 97202, p: 503-231-9879 f: 503-233-4732 amy lennon, dc • cliff marhoefer, dc

PATIENT REQUEST FOR RECORDS

DATE: _____

I HEREBY AUTHORIZE THE RELEASE OF MY:

- X-RAYS CHART NOTES
 SPECIAL REPORTS MRI/CT LAB REPORTS
 OTHER _____

DATE OF RECORDS _____

FROM:

NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE _____
FAX _____

PLEASE TRANSFER TO:

- HAWTHORNE CHIROPRACTIC**
1222 SE DIVISION ST.
PORTLAND, OR 97202
Ph 503.231.9879 Fax 503.233.4732

- DOCTOR OR HOSPITAL:** _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE _____
FAX _____

- SELF:**
PRINT NAME OF PATIENT _____
PATIENT SIGNATURE _____
DATE OF BIRTH _____