



# FAMILY FIRST

CHIROPRACTIC CENTER

## PATIENT REQUEST FOR MEDICAL RECORDS

*Wellness care for the entire family.*

Date: \_\_\_\_\_

Medical record release from:

Dr. Nichole Rakow DC  
11901 Hwy 65  
Blaine, MN 55434

“I hereby authorize the release of my \_\_\_\_\_ or

Copies of such and request that they are transferred to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FAMILY FIRST

11901 Hwy 65  
Blaine, MN 55434

Phone: 763-404-6244  
Fax: 763-404-6244

Print Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of Records: \_\_\_\_\_

Patient’s Signature: \_\_\_\_\_

Record release for the purpose of: \_\_\_\_\_

Please note: This request will expire 6 months after the date of signature. The patient reserves the right to cancel this release at any time by submitting a written request to the address on the left side of this form. A photocopy of this form is valid as original if it has not been altered. Redisclosure of protected health information will no longer be protected under the federal privacy rule. Not signing this form will not result in the denial of treatment.