FAMILY FIRST
CHIROPRACTIC CENTER

PATIENT REQUEST FOR MEDICAL RECORDS

Wellness care for the entire family.

FAMILY FIRST

11901 Hwy 65
Blaine, MN 55434

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

Date:_____

Records requested from:

_____

_____

_____

_____

"I hereby authorize the release of my _____ or Copies of such and request that they are transferred to:

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

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.