REQUEST FOR MEDICAL RECORDS

DATE OF REQUEST: ___________________________

PATIENT INFORMATION

Patient Name (Print):	
Date of Birth:	

Name and address of Doctor that records are being authorized to be released from:

Name:	
Address:	
Phone #:	

SEND THE FOLLOWING RECORDS/REPORTS/FILMS:

- Medical/Chiropractic Records (Recent records only). Do not include billing records.
- Medical/Chiropractic Records (All past records.) Do not include billing records.
- Imaging report and films ____
- Lab reports

SEND MEDICAL/CHIROPRACTIC RECORDS TO:

The following Doctor/Facility has authorization from this patient to request release of medical records to:

Doctor's Name:	Christine Teaño Lipat, DC, Niu Health Chiropractic
License #:	1182
Address:	1110 University Ave, Ste 304, Honolulu, HI 96826
Phone #:	(808) 783-1046
Z-sentry secure e-mail:	niupatients@gmail.com

I, (Patient, print name) _________________________________, hereby request and authorize the above records to be released and mailed to the doctor/facility indicated in this form. It is understood that any X-ray original films will be returned to the originating facility within 30 days after receiving them.

Signature of Patient:____ Date: _______________