RECORDS RELEASE

Date: _____

To: _____
Doctor or Hospital/Clinic

_____
Address

_____

I hereby request that you release to:

Knoxville Chiropractic Clinic

115 East Main St. Knoxville, Iowa 50138

_____

☐	**X-Ray**	**Copy with report**	**Report Only**
☐	**MRI**	**Copy with report**	**Report Only**
☐	**CT**	**Copy with report**	**Report Only**

☐ **The complete medical records in your possession, concerning my illness and/or treatment during the period requested.**

Dates of service from _____ **to** _____

Print Name: _____

DOB: _____

Signature: _____

Date: _____

If you have questions regarding this release please contact:

Knoxville Chiropractic Clinic
Dr. Larry Formanek
115 E. Main St.
Knoxville, IA 50138
Ph. 641-842-3007
Fax 641-842-5612