Patient Request for Records

Performing Edge Chiropractic
Schaaf Chiropractic LTD.
4534 S State Route 4
Attica, OH 44807

Date: _____ / _____ / __________

I, ____ hereby authorize **Schaaf Chiropractic LTD.** to release my:

Circle All That Apply

- Records
- X-Ray Films

Release To: ____
(Doctor/Hospital)

Address: ____

City: ______________________ State: _______ Zip: __________

From: _____ / _____ / __________ To: _____ / _____ / __________
(Dates of Records Needed)

____
Patient’s Signature