CHIRO REHAB CENTER

220 Hamburg Turnpike Suite 14A • Wayne, NJ 07470 | T:(862) 336-1600 • F:(862) 336-1601

Medical Record Request

To: ______________________________

Address: ______________________________

City, State & Zip: ______________________________

I, hereby authorize the release of my Medical records or copies of such and request that they be sent to the provider mentioned below:

AKM Chiro-Rehab Center, LLC

______________________________ (Name of Patient)

______________________________ (Witness)

______________________________ (Patient/Parent/Guardian Signature)

______________________________ (Dates of Service)

Patient's Date of Birth: ______________________________

Patients SSN: ______________________________

Thank you in advance for your cooperation in providing us with the requested information.

Should you have any questions, pleae feel free to contact us at the number up top.

Translated by: ______________________________
(Employee Name)