KENNETH A. FELT, D.C., D.A.B.C.O.
Certified Chiropractic Orthopedics and Acupuncture

P.O. Box 121044
Clermont, Florida, 34712-1044
(352) 394-5100
Fax: (352) 394-0122

Record Release Request

Date Requested_____

Date of Birth: _____ **Social Security #** _____

I, _____**(patient name),**
a patient of Dr. Kenneth Felt, D.C., D.A.B.C.O. hereby request and authorize
_____ **to release all medical records or those listed below concerning myself to Dr. Kenneth A. Felt, D.C., D.A.B.C.O. of Felt Chiropractic.**

Please fax all requested information to the following: 352-394-0122

Records and Documents requested below

□ **Doctor's Notes and any information including the diagnosis and records of any treatment or examination rendered to me during the period from** _____ **to** _____.

□ **MRI Reports** _____

□ **Radiology Reports** _____

□ **Other Requested Documents** _____

Patient Phone # _____

Patient Signature _____ **Date** _____

Thank you for your prompt attention to this request