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Comprehensive Care of Neck and Back Disorders
Phone: 214.370.3535 / Fax: 214.370.0004
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Individual Request by Patient/Guardian for a Copy of the Patient's Record

Name of Patient ____
Date of Birth ____
Address ____
____
Phone Number ____

I, ___________________________________, request a copy of my medical records from
_____________________________________ *Name of Physician or clinic.*

Records requested from ______________________ (date) to ________________________ (date).
I request the records be provided to me (check one)

- ☐ Electronically (secure email)
- ☐ Paper copy

I would like the records delivered to me by (check one)

- ☐ USPS mail
- ☐ I will pick up
- ☐ I will have someone else pick up my records _________________________________ *specify who will pick up*

I would like my medical records directed to ____.
(specify name and address of third-party to receive your medical records)

Printed Name and Signature of Patient or Parent or Personal Representative

________________________ ____
Date _____________________________________

Request Fulfilled Date ________________ by ___________
Request Denied Date ________________ by ________________ reason _____________________