Chiropractic Therapeutics

Dr. Logan Martin

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Patient Request for Records

Patient Name: ___________________________________

Date of Birth: ______________

To: ____
Doctor/Hospital/Clinic

Address: ____

City: __________________________ State: __________

I hereby authorize the release of my medical records or copies of such and request that they be transferred to:

Logan Martin DC
1104 N 4th St. Ste B
Coeur d'Alene, ID 83814
(208) 292-4873 fax (208) 292-4875

Dated: ____________________

Patient signature: _______________________________________

Printed Name: ____

Relationship to patient: _________________________________