PATIENT REQUEST FOR RECORDS/X-RAYS

Date:__________________

Facility: ____________________________________

Address: ____________________________________

City/State: ____________________ Zip:______________

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

David A. Kling, D.C.
225 E. Sonterra Blvd. Ste. 113
San Antonio, Texas 78258

Patient:______________________
(print)

From: ________________ to _________________
(dates of records needed)

Patient Signature:____________________________

Staff Signature: _____________________________