

**PATIENT REQUEST FOR
RECORDS/X-RAYS**

Date: _____

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

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

Facility: _____

Address: _____

City/State: _____ Zip: _____

Patient: _____
(print)

From: _____ to _____
(dates of records needed)

Patient Signature: _____

Staff Signature: _____