Condition For Life
Wayne R. Nelson, DC, ACRB-L2
335 So. Spring Street, Klamath Falls, Oregon 97601
P 541.887.2223 F. 541.887.2228

Records Release Request

Patient Name_____ Date of Birth_____

Address _____City_____ State___ Zip code_____

Release Records From:_____

Address _____City_____ State___ Zip code_____

Phone Number (_____)_____Fax Number (____)_____

_____ Chart Notes _____ X-ray Report _____X-ray Films _____ Billing Ledger

_____ Other (please specify) _____

Release Records To

Condition For Life
Wayne R. Nelson, DC, ACRB-L2
335 So Spring Street. Klamath Falls, OR 97601
O. 541.557.2223 F. 41.887.2228

I authorize the release of the above information that I have requested to be sent within 30 days from receipt of the released signed date.

I give permission to fax the information requested (with the exception of x-rays) by including my initials _____.

In compliance with HIPAA guidelines this information is confidential and will be used for the purpose of review solely by Dr. Nelson. Furthermore, a copy of this release is as good as the original.

Patient Signature _____ Date _____

Whitness Signature _____ Date _____