Southern Spine & Sport
CHIROPRACTIC, REHAB, MOVEMENT SPECIALIST

MEDICAL RELEASE

I, (Patient's Name) _____ request and give my permission to release my medical records for the time period _____ to _____ - OR - ☐ ALL RECORDS from the following Medical Clinic:

Name of Person / Clinic / Office _____

Fax # _____

Address _____

_____

City, State, Zip _____

SPECIFIC RECORDS REQUESTED

☐ Physician Notes

☐ Labwork

☐ Imaging Results (X-Ray, MRI, CT)

- or -

☐ ALL RECORDS

WHERE SHOULD YOUR RECORDS BE SENT?

The requested medical records should be sent to:

SOUTHERN SPINE & SPORT LLC
3055 KIRKLAND CIR. MOUNT JULIET, TN 37122
PHONE: 615-200-0454 FAX: 615-499-6684
E-MAIL: OFFICE.SOUTHERNSS@GMAIL.COM

_____ ___/___/_____ _____

Patient Printed Name | Date of Birth | Last 4 digits of Social Security # for Verification