Lifetime Family Chiropractic

David C. Pamer, D. C.
Mathias G. Pamer, D.C.

3848 Medina Road, Suite 101
Medina, OH 44256
Phone (330) 721-9300
Fax (330) 721-9307

Release of Records Request

By signing below, I am requesting a copy of my records from
Lifetime Family Chiropractic to myself.
I am taking full responsibility for my records.

Patient's PRINTED Name: ______________________________

Previous Last Name (if applicable): ______________________________

Patient Phone #: ______________________________

Date of Birth: ______________________________

Last four digits of SSN: ______________________________

Please provide the address to which you would like your records sent to
(PLEASE PRINT CLEARLY):

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______________________________ Patient's Signature

______________________________ Date of Request