27850 Gratiot Avenue
Roseville, MI 48066
Phone (586) 772-5876
Fax (586) 772-1122

LUPO
chiropractic center

RELEASE OF CLINICAL RECORDS

Date: _____

To: _____ From: Dr. Joseph Lupo
Medical Records Dept.
Phone _____ Phone (586) 772-5876
Fax _____ Fax (586) 772-1122

Re: Medical Records
Patient Name _____
Patient DOB _____

I, _____, request and consent to the release of information for the purpose of treatment at Dr. Joseph Lupo's office:

Records requested: ☐ MRI ☐ X-ray ☐ History
☐ Diagnosis ☐ Treatment ☐ Reports

Concerning: ☐ Accident on _____
☐ Any care given at your facility

Please send to: Dr. Joseph Lupo
27850 Gratiot Avenue
Roseville, MI 48066

Patient Signature _____ Date _____

I certify that the protected health information of the above referenced patient will be used solely for the purposes of treatment, payment and operations. This facility complies with all applicable federal privacy statutes.

Witness _____ Date _____

Outside Medical. "Release of Records mm-dd-yyyy"