

## MEDICAL RECORDS REQUEST

Please fill-in the name of the physician, hospital, or clinic you are requesting info from:

**To:** Name \_\_\_\_\_  
Street \_\_\_\_\_  
City/Zip \_\_\_\_\_  
Fax \_\_\_\_\_

**Re:** Pt. Name \_\_\_\_\_  
DOB \_\_\_\_\_

The above patient is under the care of Dr. Thomas J. Francescotti, ND. Please forward the following information as soon as possible:

**(PLEASE FAX TO 845-876-5559)**

\_\_\_ Laboratory work  
\_\_\_ X-rays, CT scans, MRI, any other imaging studies  
\_\_\_ Other \_\_\_\_\_

For Time period: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ (see above) to furnish the above requested information contained in my medical record to Tom's Tonics-A Modern Apothecary.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_