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To:

Fax:

Patient:

Date of Birth:

Requested Reports:

To whom it may concern:

This shall be your good and sufficient authority and you are hereby authorized and directed to fax to us the above requested copies which may include x-rays, reports, Emergency Department records, clinical notes and records, consultation reports, correspondence between doctors, physiotherapy notes, nurses' notes, operative notes and generally anything relating medically to the undersigned.

I understand that the personal information obtained through this request will be used by

- Dr. Thomas S. Sartor, B.A., D.C.
- Shannon O'Neill, RPT, CAFCI

for the investigation and collaboration of my medical condition and treatment.

Signature of Patient

Date

Witness

Date