SNYDER PHYSICAL THERAPY & Sports Rehabilitation

Snyder Physical Therapy & Sports Rehabilitation ● New West Orthopaedic & Spots Rehabilitation

Patient Request for Release of Medical Records

Patient Requesting Records Release:

Name: _____

Address: _____City: _____ State: _____ Zip: _____

Date of Birth: _____

I hereby request that my medical records be release to:

☐ ☐ (Where you would like your records send)

Snyder Physical Therapy & Sports Rehabilitation **OR** _____
2845 South 70th Street, Ste 1 _____
Lincoln, NE 68506 _____

Phone#: 402/489-1999 Fax#: 402/489-4153 Phone#: _____ Fax#: _____

Date range of medical release request:

Start Date: _____ End Date: _____ or _____: **Initial if requesting all past medical records**

Reason for records request: (optional) _____

_____

_____

_____

Signature of Patient (Guardian): _____ Date: _____