ROCKY MOUNTAIN CHIROPRACTIC & SPORTS INJURY CENTERS, P.C.

Brent G. Hextell, DC, CSCS

8010 S CR 5, Suite 209
Windsor, CO 80528-9004

ph. (970) 674-0147
fx. (970) 674-0145

www.ChiropracticWindsor.com

Dear_____
In order for us to provide you the best service possible, please provide your consent for the following imaging study request. Our doctor will review your x-rays, CT or MRI, ect study upon receipt of the imaging. This valuable information will assist in providing the best care possible.

Imaging Center/Practice Name: _____

City, State of clinic: _____Office Phone: _____

Office Fax: _____ Records Dept Email: _____

To Whom It May Concern:

I hereby authorize_____to release the following information to:

Rocky Mountain Chiropractic and Sports Injury Centers
8010 S CR 5, Suite 209
Windsor, CO 80528-9004
(970) 674-0147

Documents Requested:

All Imaging Studies (X-Ray, MRI, ect) and Reports. Please send the actual studies for our clinical review and not only the reports.

Patient Name:_____

Patient Date of Birth: _____

Patient Signature:_____

Date of Signature:_____