



**THE BACK
ALLEY**

CHIROPRACTIC & MASSAGE

DONALD K SHIFLET, DC
CHIROPRACTIC PHYSICIAN

RECORDS REQUEST FORM

To: _____

Fax: _____ **Phone:** _____

From: Donald K Shiflet DC

Fax: (520) 877-9183 **Phone:** (520) 877-2666

Address: 2060 E Tangerine Rd Ste 182, Oro Valley AZ 85755

Patient Info:

Name _____ **Date of Birth** _____

Signature _____

Type of Request:

CD images X-ray Film images Report only Medical Records

Exam Requested:

C-Spine T-Spine L-Spine Pelvis SI Joints Sacrum & Coccyx

Head & Neck Chest Ribs Abdomen Ribs

Upper Extremity: _____ Lower Extremity: _____

Other: _____

MRI: _____ CT: _____

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