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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: _____