Fax Transmittal From:
Mary Jo Marraffa, D.C.
Phone: (614) 847-1100
Fax: (614) 847-9200

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Patient Request for Records

To:____

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Phone: ____________________________ Fax: ______________________________

I hereby authorize release of my:

- ☐ X-Rays
  - ☐ Please mail films/CD
  - ☐ Please fax X-ray report
- ☐ Lab work
- ☐ MRI
  - ☐ Please mail films/CD
  - ☐ Please fax MRI report
- ☐ Test Results
- ☐ Report
- ☐ Entire File

Or copies of such and request that they be transferred to:

Mary Jo Marraffa, D.C.
881 High Street
Worthington, OH 43085

Phone: (614) 847-1100
Fax: (614) 847-9200

______________________________ ______________ ______________
Print Patient Name Date of Birth Date of Records

XXX-XX-
______________________________ ______________________________
Social Security Number (last 4 digits) Signature of Patient

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