

**Request for Records** Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

To: \_\_\_\_\_ Phone:(\_\_\_\_) \_\_\_\_ - \_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_, \_\_\_\_ - \_\_\_\_  
\_\_\_\_\_ Fax:(\_\_\_\_) \_\_\_\_ - \_\_\_\_

I hereby authorize the release of my  
 Lab reports  X-ray/MRI reports  Complete records  Other \_\_\_\_\_  
or copies of such and request that they be transferred to Michael A. Winters, D.C.  
Date(s) of Records: \_\_\_\_\_

**Winters Wellness Center** Date of Appointment: \_\_\_\_\_  
2830 Lone Oak Road, Ste. 4 Patient: \_\_\_\_\_  
Paducah, KY 42003 Signature: \_\_\_\_\_  
Phone: (270) 554-2141 Date of Birth or SSN: \_\_\_\_\_  
Fax: (270) 554-8795

**Request for Records** Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

To: \_\_\_\_\_ Phone:(\_\_\_\_) \_\_\_\_ - \_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_, \_\_\_\_ - \_\_\_\_  
\_\_\_\_\_ Fax:(\_\_\_\_) \_\_\_\_ - \_\_\_\_

I hereby authorize the release of my  
 Lab reports  X-ray/MRI reports  Complete records  Other \_\_\_\_\_  
or copies of such and request that they be transferred to Michael A. Winters, D.C.  
Date(s) of Records: \_\_\_\_\_

**Winters Wellness Center** Date of Appointment: \_\_\_\_\_  
2830 Lone Oak Road, Ste. 4 Patient: \_\_\_\_\_  
Paducah, KY 42003 Signature: \_\_\_\_\_  
Phone: (270) 554-2141 Date of Birth or SSN: \_\_\_\_\_  
Fax: (270) 554-8795