Michael A. Winters, D.C., PSC
4965 Village Square Drive, Suite B
Paducah, KY 42001

winterswellness.com
Phone: (270) 554-2141
Fax: (270) 554-8795

Patient: ____

Date of Birth: _______________ SSN#: ____________________

Signature: ____________________________ Date: ___________

Doctor/Facility: ____

Phone: (_____) ______-___________ Fax: (_____) ______-___________

I hereby authorize the release of my:

□ Lab reports □ X-ray/MRI/CT reports □ Other ___________________

or copies of such and request that they be transferred to Michael A. Winters, D.C.

Date(s) of Records: □ Last 2 years □ Other ______________________

Please **FAX** my records to Winters Wellness Center at **(270) 554-8795**. Thank you!

Doctor/Facility: ____

Phone: (_____) ______-___________ Fax: (_____) ______-___________

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