# ***Records Transfer Request***

Outgoing

Date: _____

To: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

I hereby authorize the release of my: □ X-Rays □ Records □ Other:_____

## ***Knewtson Health Group***

23505 Smithtown Road Suite 100
Excelsior, MN 55331
952-470-8555
Fax 952-401-8785

Name of Patient: _____ Signature: _____

Patient DOB: _____

Patient Address: _____

_____

***We are lending these x-rays as a courtesy to our patient. These films are legally a part of our permanent records. Please do not send the films with the patient or lend them to any other facility without our release.