PATIENT REQUEST FOR TRANSFER OF RECORDS

CONNER CHIROPRACTIC CARE
91 Cernon Street, Ste. B
Vacaville, CA 95688
707 447-8100 ph
707 447-9900 fax

Date: _____

To: _____
Doctor/Hospital

Address: _____

City: _____ State: _____ Zip Code: _____

I hereby authorize the release of my ☐ health records ☐ x-rays ☐ MRI ☐ reports or copies of such and request you transfer them to:

CONNER CHIROPRACTIC CARE
91 Cernon Street, Ste. B
Vacaville, CA 95688
707 447-8100 ph
707 447-9900 fax

_____ _____
Print name of patient Signature (patient, parent or guardian)