Records Transfer Request

Incoming

Date: __________

To: ____

Address: ____________________________________

City: _________________ State: _______ Zip Code: ____________

Phone: ________________ Fax: _____________________

I hereby authorize the release of my: ☐ X-Rays ☐ Records ☐ Other:__________
Please send my records to:

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: _________________________

____