DATE:_____

RECORDS TRANSFER REQUEST

TO:_____

(DOCTOR / HOSPITAL)

PHONE:_____ FAX:_____

ADDRESS:_____

CITY:_____ STATE:_____ZIP:_____

I hereby authorize the release of my _____ or

Copies or such and request that they are transferred to:

TURNING POINT CHIRORACTIC AND WELLNESS INC

2745 CHURCH ST. EAST POINT, GA 30344

PHONE: (404) 761-4441 FAX: (404)549-4220

EMAIL: TURNINGPTWELLNESS@GMAIL.COM

_____ _____

Signature Date of Birth

_____ _____

Print Name Treatment Dates (if known)