KANADY

CHIROPRACTIC CENTER

RECORDS TRANSFER REQUEST

Date: _____

To: _____

Address: _____

City: _____ State: _____ Zip: _____

I hereby request my records and/or x-rays, or copies of such be transferred to:

Dr. Tim Kanady ● Dr. Trevor Tew
Kanady Chiropractic Center
1113 W Fireweed Lane, Suite 100
Anchorage AK 99502
(907) 272-2700 Fax: (907) 272-2702

_____

Printed Name of Patient Patient's Date of Birth

_____

Signature of Patient or Guardian