Records Transfer Request

Date: ______________________________

To: ____

(Doctor/Hospital Receiving Records From)

Address:____

City:_________________________________ State:_______________ Zip:_____________

Phone:______________________________ Fax:_________________________________

I hereby authorize the release of my following records to be transferred to Dr. Ron Grabowski.

IF OVER 10 PAGES PLEASE MAIL TO THE ADDRESS BELOW.

[ ] **Medical Records**

[ ] **Laboratory Test Results**

[ ] **X-rays/MRI/CT Scan Results**

[ ] **All Records**

[ ] **Additional Requests** ____

Dr. Ron Grabowski, R.D., D.C.
<u>Houston Sports, Rehabilitation and Nutrition Center, LLC</u>
1201 Dairy Ashford, Suite 116
Houston, Texas 77079
Phone: 281-497-7070
Fax: 281-497-7077

Patient DOB_______________________ **Patient Phone**__________________________

___________________________________ ___________________________________

Print Name of Patient **Signature (Patient, Parent or Guardian)**

Revised-10/1/10