Date:

Please transfer the medical records of the patient(s) listed below to:
If child is 18 yrs or older we require the signature of the patient.

Doctor's Name_____

Address_____

City_____

State_____ Zip_____

Phone Number _____ Fax Number _____

PATIENT:

_____

Last Name First Name DOB

Reason for Transfer:

_____ _____

Patient or Representative's signature Date

_____ _____

Printed Name of Representative Relationship to Patient

NOTE: The facility/person named above may have access to any and all medical health information; discussion, treatment of the named patient.