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If record is more than 20 pages please email or mail ONLY

RECORDS TRANSFER REQUEST

Name of Patient:_____. DOB:_____

To:_____
(Doctor/Hospital)
Address:_____
Phone:_____. Fax:_____

I hereby authorize the release of copies of all medical records for my child (rens) and request that they be transferred to the above mention doctors.

_____.
Signature (Patient, Parent or Guardian)

Child#2
Name: _____. DOB:_____
Child#3
Name:_____.DOB:_____
Child#4
Name;_____.DOB:_____