Chingchai Wanidworanun, MD, PLLC
4001 9th Street, North, Suite 228
Arlington, Virginia 22203

Phone: (703) 387-0999
Fax: (703) 387-0911
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RECORDS TRANSFER REQUEST

TO:

Name of Physician/Facility: ____

Address: ____

Phone Number: ____

Fax Number: ____

I hereby authorize the release of my medical records, or copies of such, and request that they be transferred to:

Chingchai Wanidworanun, MD, PLLC
4001 9th Street, North, Suite 228
Arlington, VA 22203
Phone: (703) 387-0999
Fax: (703) 387-0911

_____ Any and all records related to past and present medical histories, diagnoses, and treatment

_____ Specific medical records: ____

Signature of Patient: ____

Patient Name: _______________________________________

Social Security Number: _________________________________

Date of Birth: ____

Date: _______________________________________