RECORDS TRANSFER REQUEST

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

Name of facility/physician: ____

Address: ____

Phone Number: ____

Fax Number: ____

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

_____ Specific medical records: ____

Signature of Patient ____

Name of Patient ____

Date of Birth ____

Date ____

Note: Record has been picked up by the patient ______ Patient's initials _______

Record has been sent by ____________, to ___________________________,

on_____________________________.