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RECORDS TRANSFER REQUEST

Due to Dr. Wanidworanun' Retirement

Patient: Please fill in the form below.

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: _____

To myself: In my USB storage device provided to the doctor:_____.
To my email address:_____.

____ 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: _____ Phone Number: _____

Email: _____

Date: _____

_____

Clerk to fill below:

Record has been picked up by the patient _____ Patient's initials _____

Record has been sent by _____, to _____,

on_____.

Clerk initial:_____