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REQUEST FOR MEDICAL RECORDS TRANSFER

Current Physician:

Name

Address

City, State, Zip Code

Phone Fax

PLEASE TRANSFER THE FOLLOWING INDICATED INFORMATION AND MEDICAL RECORDS CONCERNING MY CHILD'S/CHILDREN'S CARE TO THE FOLLOWING PHYSICIAN OFFICE:

Physician Name

Address

City, State, Zip Code

Phone Fax

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Patient Name:_____ DOB: _____

Patient Name:_____ DOB: _____

Signature:_____ Date:_____

Relationship to Patients:_____