

RELEASE OF RECORDS

To request patient records to be prepared for transferring to another Doctor, fill out this form completely. Please PRINT. Incomplete forms may delay processing. Thank you.

Date of Request: _____

Due Date of Request: _____
(at least 5 days notice)

Patient Account Number: _____

Home Phone: _____

Patient Name: _____
(street address)

Patient Address: _____

(City) (State) (Postal Code)

Current Doctor: _____

Transfer to Doctor: _____

New Dr's Address: _____
(street address)

(City) (State) (Postal Code)

Name of Patient(s) on Account to be Transferred: _____

Reason for Transfer: _____

Delivery Instructions: Patient will pick-up Mail to Patient Mail to New Doctor

Patient/Guardian Signature: _____ Date: _____