Twelve Corners Pediatrics

www.twelvecornerspediatrics.com

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REQUEST FOR TRANSFER OF INFORMATION
FROM TWELVE CORNERS PEDIATRICS

Patient Name: _____________________________________ DOB: ____________________
(Please Print)
Patient Address: _____________________________________
____
____

Patient/Parent day phone: (   ) ________________________

I request a copy of my protected health information. I want a copy of: (Please choose any and all that apply)

□ Summary of my entire medical record

□ Lab Test Results

□ Immunizations
(Doctor's Fax # _____________________)

□ Psychiatric Information

□ Last History and Physical

□ Educational Information

□ Chart notes relating to: _________________

□ Other ______________________

Please be advised that unless specifically requested, all Psychiatric and Mental Health information cannot be sent

For the purpose of: (Please choose one)

□ Transfer of Care Reason for transfer: _______________________________________

□ Temporary release (for consultation) to end: ___________________________________
(If no date stated this release will end one year from date this release is signed)

Release information to: ____
(New Doctor's Name)
____
____
____
(New Doctor's Address)

If you have requested a summary of your record we will advise you in advance of the fee for the summary, if any. We will charge a fee for a copy of the complete medical record. Our fee is governed by law and is $.75 per page copied.

____ Date: _______________
Signature of patient or Personal Representative (If under age 18)

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