



Twelve Corners Pediatrics

www.twelvecornerspeditrics.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)

<input type="checkbox"/> Summary of my entire medical record	<input type="checkbox"/> Lab Test Results
<input type="checkbox"/> Immunizations (Doctor's Fax # _____)	<input type="checkbox"/> Psychiatric Information
<input type="checkbox"/> Last History and Physical	<input type="checkbox"/> Educational Information
<input type="checkbox"/> Chart notes relating to: _____	<input type="checkbox"/> Other _____

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

For the purpose of: (Please choose one)

<input type="checkbox"/> Transfer of Care Reason for transfer: _____
<input type="checkbox"/> 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.

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