# Medical Records Transfer Request

Patient Full Name:

[                    ]

Date of Birth:

[                    ]

From (Current Healthcare Provider):

[                    ]

To (Receiving Healthcare Provider):

[                    ]

Receiving Provider Address:

[                    ]

Receiving Provider Phone/Fax:

[                    ]

Records to be Transferred (please specify):

[                    ]

Authorization Signature:

[                    ]

Date Signed:

[                    ]

Submit Request