Pediatric Specialties, PA

AUTHORIZATION TO TRANSFER RECORDS

Date: _____

I am requesting that the records of my child/children

Name	**Date of Birth**
_____	_____
_____	_____
_____	_____
_____	_____

Be transferred to: _____
_____
_____

For the following reason:

_____ **Moving out of the area** _____ **Over 21 years of age**
_____ **Insurance plan change** _____ **Unhappy with Practice**
_____ **Other, please explain** _____
_____
_____

I understand that there is a charge for this service which will be discussed with the medical records department.

Parent or Guardian signature _____
Phone: Home_____ **Cell** _____