23480 Park Sorrento | Suite 109A
Calabasas | CA 91302
Tel: 818-914-4429
Fax: 844-882-5036

REQUEST FOR TRANSFER OF HEALTH INFORMATION / MEDICAL RECORDS

As required by the Health Information Portability and Accountability Act of 1996 (HIPPA), this practice may not disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the transfer of health information described below. Please review and complete this form carefully. It may be invalid if not fully completed.

I HEREBY REQUEST THE TRANSFER OF RECORDS FOR:

Patient's Full Name: ____

Date of Birth: _____/_____/_____

Address: ____

City/State/Zip Code: ____

Daytime Phone Number: (   ) __________________________ □ Cell # □ Work # □ Home #

TYPE OF RECORD REQUESTED: ____

TO BE TRANSFERRED FROM:

Practice Name: ____

Address: ____

City/State/Zip Code: ____

Phone Number: ____

TO BE TRANSFERRED TO: **Calabasas Pediatrics, at the address above**

Parent / Legal Guardian Full Name: ____

Parent / Legal Guardian Signature: ____

Date Requested: _____ / _____ / _____

By my signature I certify that I am the parent or legal guardian of the parent named here. If there is more than one Child in the family, please complete a separate form for each child.