RECORD TRANSFER REQUEST
($20.00 charge per child applies)

Please transfer the medical records for my child _____
D.O.B____/____/_____ to:

I UNDERSTAND THAT:

- Information released by this authorization may then be re-released by the recipient and may no longer be protected by the Privacy Rule.
- I release this office from all legal responsibility or liability that may arise from this authorization.

Parent signature: _____ Date:_____

RECEIVING MEDICAL OFFICE: In order to avoid duplication and keep an accurate file of our transfers, please acknowledge receipt of the medical records of:

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which were processed by Associated Pediatric Partners S.C. on _____, by signing and dating this form and either faxing or mailing it to our office.

Fax: 847-498-6164 or 847-520-6091

We thank you for your cooperation.

RECORDS RECEIVED BY : _____

PRACTICE NAME: _____

DATE :_____

M. Belinda Radis, M.D. • Dov Y. Shapiro, M.D. • Asha Varghese, M.D. • Cheryl Donovan-Hunt, M.D.

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visit us: associatedpediatricpartners.com