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TRANSFER OF RECORDS REQUEST

(from another office to our offices)

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT PHONE: _____

In accordance with HIPAA legislation, I am exercising my right to access my PHI in the form of medical records created in your office. Please send my medical records to the office indicated above, using the address or fax number shown above. I am requesting that the following be sent:

☐ Face Sheet (demographics and basic information)

☐ Office Visit notes

☐ X-ray images

☐ Surgical/ Operative care reports

☐ Pathology reports

Please send records dated from _____ to _____.

I understand that any fee for medical records must be paid by me, and the office listed above is not liable for any fees that may apply.

RECORDS HOLDER: _____

OFFICE / PHYSICIAN NAME

_____ _____

FAX NUMBER PHONE NUMBER

☐ Please call me (the patient) once records have been sent.

_____ _____

PATIENT/ LEGAL GUARDIAN SIGNATURE (if guardian please print name also) TODAY'S DATE