Center City Pediatrics

CHART TRANSFER REQUEST

(please print legibly)

Date: _____

I hereby authorize Center City Pediatrics, LLC to release MEDICAL records to:

Office Name: _____

Address: _____

City:_____State:_____Zip: _____

Phone #:_____Fax #: _____

Child's Name LEGAL FIRST AND LAST NAME **{PLEASE PRINT LEGIBLY}**	Child's Date of Birth MONTH, DAY AND YEAR

Method of chart (circle one): secure cd secure flash drive fax U.S mail

Which best describes the reason why you are transferring? Please select all that apply:

	Moving out of the area, If so location:
	My children are transitioning to an adult practice
	Distance and convenience to my home [too hard to get to]
	I was not satisfied with the quality of care provided to my children
	I was not satisfied with the access to appointments
	Other (please specify):
Additional Feedback and Comments: (Please feel free to use the back of this form should you need additional space)	

Parent/Guardian Phone Number: _____

Parent/Guardian Signature: _____

****Please note that Center City Pediatrics utilizes a third party, DataFile Technologies, to handle and complete the transfer of all charts. Feel free to call them directly with any questions @* 816.437.9134