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 #: ________________________

For the following child(ren):

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 thumb/flash drive   fax   U.S mail

Reason for transfer: ________________________________

If moving, location: __________________________

Parent/Guardian Phone Number: ________________________

Parent/Guardian Signature: ______________________________________

Parent/Guardian Email address:____

(This email address will be used to send an exit survey just to let us know how we are doing and any suggestions for improvement. We would appreciate your time in completing this exit survey.)

****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