Arlington Physicians

PEDIATRICS

Transfer Out

Patient (s) Name: _____

Birthdate (s): _____

Current Address: _____

New Address: _____

Current Physician: _____

Purpose for copying records: ( ) Applying for insurance
( ) Leaving the group
( ) Other

If leaving the group, reason: ( ) Moving out of town
( ) Unhappy with service
( ) Insurance not taken here: List Ins. _____
( ) Other

I hereby authorize and request the release of all medical records to: _____
_____
_____

Parent / Guardian Signature: _____ Date: _____