Family Physicians Group
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Transfer of Medical Records

Attention: Medical Records

Patient Name: ______________________________ Date of Birth: ____/____/____

Address: ______________________________ City: ______________

State/Zip Code: ______________________________ Phone: ______________

I authorize the custodian of records of (Provider): ______________________________

Address: ______________________________

City: ______________ State/Zip: ______________

Phone: ______________ Fax: ______________

To disclose/release my records to the following: ______________________________

Address: ______________________________

City: ______________ State/Zip: ______________

Phone: ______________ Fax: ______________

Reason for Transfer:

_____ Moving

_____ Switching Doctors

_____ Personal Use

_____ Other ______________

_____ Second Opinion; not transferring

Signature of Patient: ______________________________ Date: ____/____/____

Maiden Name: ______________

Signature if other than patient: ______________________________ Date: ____/____/____

Relationship: ______________

Number of pages: _______ Signature of Individual Making Disclosure: ______________

This authorization will remain in effect for twelve months after the date that appears above.

The patient or individual requesting medical records may revoke the authorization in writing to Family Physicians Group, P.C. at any time.

Please beware that your PHI may be used for payment, treatment, and healthcare operations without written authorization from you.