



PEDIATRICS:

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Transfer In

Patient (s) Name: _____

Birthdate (s): _____

Address & Phone Number:

Previous Physician's Name:

Previous Physician's Address & Phone/Fax Number:

The following individual is requesting that his/her medical records be released and forwarded to one of our offices listed above.

I hereby authorize the release of all necessary medical records to:
Arlington Physicians, P.A.

Parent / Guardian Signature: _____

Date: _____