**PEDIATRICS:**

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**Transfer Out**

Patient (s) Name: ______________________________________________________________

Birthdate (s): __________________________________________________________________

Current Address: ________________________________________________________________

New Address: ___________________________________________________________________

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: ____________________