



Twelve Corners Pediatrics

www.twelvecornerspeditrics.com

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TRANSFER OUT FORM

(Please Print)

Patient Name: _____ DOB: _____

Patient Address: _____

Patient/Parent day phone: (____) _____

I request a copy of my protected health information. I want a copy of:
(please choose one)

1) A summary of my entire medical record: _____

2) Only that part of my medical record that relates to: _____

Release informaton to: _____
(new doctor's full name)

(new doctor's address)

If you have requested a summary of your record we will advise you in advance of the fee for the summary, if any. We will charge a fee for a copy of the complete medical record. Our fee is governed by law and is \$.75 per page.

Signature of Patient or Personal Representative (If under age 18) Date: _____

NOTE: Under law, there are certain cases where we cannot release some of your protected health information of copying. We will advise you in writing if this occurs, and of your rights.

FOR PRACTICE USE ONLY:	
Date copy request received:	Date copy provided:
Date of denial of full copy requeste:	
Signature or Record Officer	Date