PATIENT REQUEST FOR TRANSFER OF MEDICAL RECORDS

Patient's Name:

_____

DOB:

_____

I hereby authorize the following (**medical facility**) _____ to release all existing medical records about my child to the Cleveland Children's Clinic at the address listed below.

Previous Provider's Phone Number _____

Previous Provider's Fax Number _____

The information will be used for the following purpose:

_____

(May be listed as "at request of parent")

Signature of Parent/Legal Guardian _____

Print Name of Parent/Legal Guardian_____

Date _____

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