Monroe Pediatric Associates, P.C. 70 Gilbert Street · Monroe, NY 10950

845-782-8616

REQUEST FOR TRANSFER / RELEASE OF MEDICAL RECORDS

NAME OF PATIENT	DOB
Records Should Be Mailed To:	
If possible, I would like to pick records up on	
Reason For Transfer:	
Signature:(Parent or Guardian)	Date:
(Parent or Guardian)	
Address:	
Telephone: (H)	(C)
IMPORTANT N	OTIFICATION
I understand that this may include sensitive in drug usage, child abuse/neglect, sexual assau termination of pregnancy, sexual preference, counseling/family interaction problems.	lt/abuse, sexually transmitted diseases,
Please specify any information that you do no	ot want released at this time: