MEDICAL RECORDS TRANSFER REQUEST FORM

Dr. Dunham Family Practice
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MEDICAL RECORDS TRANSFER REQUEST FORM

I, _____, hereby authorize and request that you transfer a copy of all records in your possession concerning any diagnosis, prognosis and recommendation, as well as other data pertinent to your treatment of the patient named below.

PATIENT INFORMATION

Patient Full Name (Please Print):	
Patient Address:	Social Security Number:
City:	Birthdate (mm/dd/yyyy):
State: Zip:	Home Phone Number:

TRANSFERRING PARTY

Authorized Recipient's Name:	
Mailing Address (Line 1):	State: Zip:
Mailing Address (Line 2):	Country
City:	Phone Number:

RECIPIENT

Jocelyn B. Dunham, MD, PA
3700 Forums Drive
Suite 200
Flower Mound, TX 75028

_____
Patient/Guardian Signature

_____
Date