CAPE COD PEDIATRICS

Authorization to Transfer Medical Records

Patient Name(s): _____

Date(s) of Birth: _____

I authorize:
Previous Medical Facility: _____

Address: _____

_____

Phone: _____

Fax: _____

To release my records to:
Cape Cod Pediatrics
PO Box 549
Forestdale, MA 02644
Phone: (508) 477-5306
Fax: (508) 477-0297

OR

I authorize Cape Cod Pediatrics to release my records to:

Medical Facility: _____

Address: _____

_____

Phone: _____

Fax: _____

_____ Please include entire medical record **except** confidential/sensitive information.

_____ Please include entire medical record **including** confidential/sensitive information

Signature of parent/patient (if 18 or older)/legal guardian:

_____ Date: _____

**If legal guardian, please provide our office with current legal documentation

THERE IS A $10 PER RECORD FEE IF RECORDS ARE PRINTED FOR PICK UP