Authorization to Transfer Medical Records

Cape Cod Pediatrics
Boston Children's Primary Care Alliance

capecodpediatrics.com
508-477-5306 | *fax* 508-477-0297

Patient information

Patient #1 last name: _____

First name: _____ MI: _____

Date of birth: _____

Patient #2 last name: _____

First name: _____ MI: _____

Date of birth: _____

Patient #3 last name: _____

First name: _____ MI: _____

Date of birth: _____

I authorize:

Previous medical facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Fax: _____

To release my records to:

Cape Cod Pediatrics
P.O. Box 549
Forestdale, MA 02644

508-477-5306
Fax: 508-477-0297

OR

I authorize Cape Cod Pediatrics to release my records to:

Medical Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Fax: _____

❍ Please include entire medical record except confidential/sensitive information.

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

_____

Date: _____

NOTE: Legal documentation is required if legal guardian is other than parent.

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