



Request to Transfer Out Medical Records

7110 Forest Avenue, Suite 105, Richmond, VA 23226

T. 804-377-7100 :: F. 804-377-8511

Each Patient(s) Legal Name	Date of Birth

Please provide the name and address of the new practice where you want to medical records to be sent.

Information About New Practice	Please provide information below.
Name of Practice	
Address of New Practice	
Phone Number of New Practice	
Fax Number of New Practice	

Please take a moment to tell us why you are leaving:

- ☐ Moving out of area
- ☐ Insurance Change
- ☐ Location Not Convenient
- ☐ Financial Reasons

Other Reason: Please explain

I understand that the physician's office listed above will receive all of my child's medical records within thirty days from the date signed, in a manner compliant with the HIPPA legislation as specified by Virginia statute. I also understand that once this information is released by Partners in Pediatrics, the information may be subject to redisclosure by the party receiving the information and may no longer be protected by federal or state law.

--

Signature of Parent, Patient or Legal Guardian

Daytime Phone Number

Date

--

Print Name

Relationship to Patient(s)