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:

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If possible, I would like to pick records up on ___________________________

Reason For Transfer:

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____

Signature: _______________________________________ Date: ___________
(Parent or Guardian)

Address: ____

Telephone: (H) _______________________ (C) _________________________

IMPORTANT NOTIFICATION

I understand that this may include sensitive information such as HIV testing, alcohol and drug usage, child abuse/neglect, sexual assault/abuse, sexually transmitted diseases, termination of pregnancy, sexual preference, history of behavioral health, and counseling/family interaction problems.

Please specify any information that you do not want released at this time:

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