MEDICAL RECORDS TRANSFER REQUEST

Date: _____

TO: _____
(DOCTOR)

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

I hereby authorize the above physician to release a complete copy of the medical record of my child to:

The Phoenix Children's Center, Ltd.
1661 East Camelback Road
Suite 170
Phoenix, Arizona 85016

(602) 263-9550 Fax (602) 263-1150

_____ _____
Print name of patient **Patient Date of Birth**

_____ _____
Print name of parent/guardian **Signature of parent/guardian**