Arlington Physicians

Transfer In

Patient (s) Name:

_____

Birthdate (s):

_____

Address & Phone Number:

Previous Physician's Name:

_____

Previous Physician's Address & Phone/Fax Number:

_____

_____

The following individual is requesting that his/her medical records be released and forwarded to one of our offices listed above.

I hereby authorize the release of all necessary medical records to:

Arlington Physicians, P.A.

Physician:_____

Parent / Guardian Signature: _____

Date: _____