DELAWARE MODERN PEDIATRICS, P.A.

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www.DMPKIDS.com

Medical Record Transfer Request

I, ______________________________, am the responsible party for the below listed minor(s). I am requesting and authorizing ______________________________, to transfer all protected health information in your possession (entire medical record) for the below listed minor(s) be transferred in electronic or paper format to:

DELAWARE MODERN PEDIATRICS
300 Biddle Avenue, Suite 206
Springside Plaza, Connor Building
Newark, Delaware 19702

Information of Doctor you are transferring records from:

Doctor: ____

Address: ____

Phone: ____

Your Children's Information:

____
Full Name Date of Birth

____
Full Name Date of Birth

____
Full Name Date of Birth

____
Full Name Date of Birth

I understand that this authorization is valid for 180 days. I clearly understand the content of this form.

____ ________________
Parent/Guardian Signature Date

Relationship to Minor(s): ______________________________