

RECORDS TRANSFER REQUEST

Date: _____

To: _____
(Doctor/Hospital)

Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize the release of my _____ or copies of
such and request that they be transferred to:

PEDIATRIC PLUS

31-87 Steinway Street, Suite 6

Astoria, NY 11103

Tel: (718) 626-4881 • Fax: (718) 626-1502

Print name of patient

Signature (patient, parent or guardian)