CAPE COD PEDIATRICS
P.O. Box 549 • 53 Route 130 • Forestdale, MA 02644
(508) 477 5306 • (508) 477-0297 FAX
e-mail: capepeds@capecod.net

Request for transfer of medical records

Patient name:_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

Please transfer the records for my children to the following medical practice:

_____

_____

_____

By completing and signing this form, I understand that I/my children will no longer be patients of Cape Cod Pediatrics LLP.

I also understand that once transferred from Cape Cod Pediatrics, LLP, I may not return to the practice if I am dissatisfied with my new medical provider.

___I am over 18 and am requesting transfer of my own records.

Signed: _____Date:_____

Printed name:_____

___I am the parent/legal guardian and am requesting permanent transfer of my children's records.

Signed: _____Date:_____

Printed name: _____

*There is a $10 administrative fee for each record prepared for transfer.

Rev. 8/06

____Copy to chart(s)
____Noted in computer by: _____date:_____