

# Medical Records Transfer Request

Please **complete and sign the form below and return it to your former medical group** so that your medical record and x-rays and/or those of your family members can be sent to the new medical group.

Each adult (18 and older) family member should sign on a separate line for the release of his/her medical records. Either parent may sign for release of records for minor (under 18) children, indicating the full name of the minor child.

It is most important that you complete and sign this release so that your new medical group will have your medical history readily available when you receive care.

Medical records are confidential documents. We will only transfer records after this consent form has been completed and signed.

**I hereby request and authorize the**

Date \_\_\_\_\_

(Fill in name of former Medical Group and address)

**TO  
RELEASE  
TO**

\_\_\_\_\_  
Medical Group

\_\_\_\_\_  
Medical Group

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

**The complete medical records in your possession for myself and/or members of my family**

Subscriber: \_\_\_\_\_  
(print name then sign full name)

Spouse: \_\_\_\_\_  
(print name then sign full name)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

HIP ID Number

Home Address

Telephone Number

City, State, Zip Code

**NOTE: EACH & EVERY DEPENDENT 18 AND OVER MUST PRINT AND SIGN FULL NAME:**

Dependent (Print full name)

Signature (if over 18)

Dependent (Print full name)

Signature (if over 18)

Dependent (Print full name)

Signature (if over 18)

Dependent (Print full name)

Signature (if over 18)

Dependent (Print full name)

Signature (if over 18)