



**CHART TRANSFER REQUEST**

Date: \_\_\_\_\_

I hereby authorize:  
Center City Pediatrics, LLC  
1740 South St, Suite 200  
Philadelphia, PA 19146

To release my MEDICAL records from the practice of my child (ren) to:

Office Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Child (ren)'s Full Name: \_\_\_\_\_

Date(s) of Birth: \_\_\_\_\_

Reason for transfer: \_\_\_\_\_

If moving, location: \_\_\_\_\_

Parent/Guardian Phone Number: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

*Please note there is a \$20 chart fee request due on each account  
BEFORE the charts are transferred.*

*Any outstanding bills on the account must be settled.*

*Only chart items from this practice will be released, we are not responsible for prior records.*

**TWO LOCATIONS. ONE GREAT PLACE FOR KIDS.**

1740 South Street, Suite 200 Philadelphia, PA 19146

146 Montgomery Avenue, Suite 200, Bala Cynwyd, PA 19004

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