Center City Pediatrics

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.