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.*