RAINBOW PEDIATRICS
MEDICAL RECORDS TRANSFER FORM
PATIENTS LEAVING RAINBOW ONLY

We are so sorry to see you go. If there is anything we can do to change your mind, please contact us immediately. Please provide us with the following information:

Patients Name:_______________________________________ DOB:________________________

SSN:_____________________________ Telephone Number:_______________________________

We are happy to send your medical records via fax to your new Pediatrician's office free of charge. Please provide us with their information below:

To:____

Address:____

Telephone Number:_______________________ Fax Number:______________________________

If you are requesting that your child's medical records be sent to you directly, there is a fee of $30 per patient and we ask that you pay in advance with a credit card. The records will be copied onto a USB drive for your convencience. Your child's records can be picked up in our office within 30 days of your initial request or will be mailed to the following:

To:____

Address:____

Telephone Number:_______________________ Fax Number:______________________________

If you could please identify the reason for your transfer below, we would greatly appreciate it.

____ Age 18 or over (seeking services other than a Pediatrician
____ Change of insurance not covered by RP Name of insurance:_________________
____ Moving out of area
____ Other (please specify)____

____ ____________________
Signature of Patient or Guarantor Date

PLEASE PROVIDE PAYMENT INFORMATION BELOW:

Cardholder Name (Printed)____

Card Number______________________________________ Exp. Date:______________________

Card Type: (Visa, Mastercard, Amex) __________________________ Security Code:____________

Cardholders Signature:____

Billing Address of the Card:____

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