

# DELAWARE VALLEY PEDIATRIC ASSOCIATES, P.A.



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## RECORDS RELEASE FORM

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

Patient Name(s):

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Release records to (practice name):

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Practice address:

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Reason for Transfer (please print):

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\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print name

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

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*\*There will be a fee of \$1.00/page up to a maximum of \$23 per individual or \$35 per family (if more than one patient) for records to be released to another provider. Copies of records for personal use will be \$1.00/page, up to a maximum of \$100.*