MEDICAL RECORDS TRANSFER AUTHORIZATION

PATIENT INFORMATION

Patient Name: _____ Date of Birth:_____

Phone: _____ Email:_____

TRANSFER MY MEDICAL RECORDS TO

Provider / Physician Name: _____

Practice / Facility Name: _____

Address: _____City: _____ State: ___ ZIP: _____

Phone: _____ Fax: _____

Secure Email: _____

PATIENT AUTHORIZATION

I authorize **Smart Prime Care** to release and transfer my medical records to the healthcare provider or practice listed above for continuity of care. I understand that once my records are transferred to the recipient, they will be maintained according to the recipient's applicable privacy practices and laws.

Patient / Authorized Representative Name:

_____ Signature: _____

Date: _____ Relationship to Patient (if applicable):_____

SUBMIT COMPLETED FORM TO SMART PRIME CARE

Phone: (540) 479-1364 **Email:** smartprimecare@gmail.com

FOR OFFICE USE

Date Received: _____ Date Records Sent: _____

Processed By: _____