doc on the block
Family Health Organization
Loyal Dependable Availiable Primary Care Provider
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NEW PHYSICIAN TRANSFER FORM – REQUEST FOR PREVIOUS MEDICAL RECORDS

I, *(Print your name)* authorize Dr. *(Print previous doctors name)* to disclose and release my personal health information to my new primary care provider Dr. *(Print your new doctor's name)* and grant appropriate access to doc on the block Family Health Organization to those records in order maintain the continuity of my healthcare and wellness.

PLEASE INCLUDE IN THAT RELEASE OF RECORDS: (Please check only one option)

☐ A full copy of my medical record (please no originals)

☐ Only a medication list, consult notes, immunization history and imaging/pathology reports

MY PERSONAL DETAILS:

Health Card Number: (###-####-###) Date of Birth: (Month/Day/Year)

My Signature: (Please sign here) Today's Date: (Month/Day/Year)

Witness Name: (Please print name of Witness here)

Witness Signature: (Please have Witness sign here)

**(ONLY complete this section below if POA designate activated and patient unable to legally represent self)*

POA Name: (Please print name of the designated Healthcare decision maker)

POA Signature: (Please have the designated decision maker sign here)

Attention physician's office: Please kindly arrange any associated fees with patient, if necessary, in order to complete this timely request without any undue delay. The CMPA guidelines suggests no longer than 30 days appropriate to comply to this request. Thank you kindly.