Transfer of Medical Records

Please transfer the medical records of:

Patient's Name Date of Birth

Street Address

City State Zip code

FROM:
Pulmonary and Sleep Physicians
501 Orchard, Suite 200
Webster, TX 77598
Ph: 281-557-8555
Fax: 281-554-3657

TO:

_____
Physician's Name

_____
Street Address

_____
City/State/Zip code

FROM:

_____
Physician's Name

_____
Street Address

_____
City/State/Zip code

TO:
Pulmonary and Sleep Physicians
501 Orchard, Suite 200
Webster, TX 77598
Ph: 281-557-8555
Fax: 281-554-3657

Please check off records that are needed:

- □ X-Ray films
- □ History & Physical
- □ PFT & Sleep Study
- □ Consultation
- □ X-ray reports
- □ Labs (Blood work, HIV tests, etc.)
- □ Progress Notes
- □ Patient Information

If patient is younger than the age of 18 or is mentally incapacitated, my signature serves as authorization:

Name: Relationship to Patient if not self:

Signature: Date: