<u>Medical Record Transfer of Care Form</u>

Patient Name: ____________________________________
Date of Birth_____/____/______
Address: ____

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Phone: ( ) __________________

I _______________________(patient name or guardian) am transferring care to a new provider. I understand that I will no longer be an active patient at Modern Family Medicine. My reason for transferring is:

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I give permission to send my medical records for continuity of care to my new provider:

Name of provider:__________________________________
Name of practice:__________________________________
Address:____

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Phone:__________________________ Fax:____________________

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Signature of patient or guardian

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Date