15215 Shady Grove Rd. # 100
Rockville, MD 20850
(301) 519-0902
Fax (301) 519-0905

Transfer Records / Copy of records Form

PATIENT'S NAME	*DATE OF BIRTH*

Person Making Request: _____ **Phone Number:** _____

Address: _____
(Street) (City) (State) (Zip Code)

Reason for Request:_____

How would you like your records delivered:

- **Fax** Attention to:_____
  Fax Number: _____
- **Mail** Attention to: _____
  Address:_____
- **Email**- email address:_____

Fee Schedule
- Preparation Fee: **$30.00**
- Charge per page (single or double sided): **$0.99**
- Postage and handling fee (may vary if large volume): **$5.00**

Patient or Guardian Signature: _____**Date:** _____

Patient Name:_____ **Relation to patient :**_____