Chester County Pediatrics, PC
690 West Lincoln Hwy, Exton, PA 19341
610-873-5437

Request for Transfer of Medical Records
Please release the medical records for the following child(ren)

Name: _____

DOB: _____

Name: _____

DOB: _____

Name: _____

DOB: _____

Name: _____

DOB: _____

Name of requesting Parent/Guardian: _____

Telephone Number of Parent/Guardian: _____

Address of Parent/Guardian (forwarding if applicable):

_____

_____

REASON FOR LEAVING:

_____

_____

**** 5-7 Business days for processing****

Circle One: **PICK UP** **MAIL**

Please send records to: _____

_____

Please choose one of the following options:

( ) Entire Chart Fee $20.00 (per child/chart)

( ) Most recent Physical and Immunizations Fee $5.00 (per child)

Parent/Guardian Signature: _____ **Date**: _____