REQUEST FOR TRANSFER OF MEDICAL RECORDS

DATE ________/_________/____________

TO: ________________________________

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NAME OF PATIENT: _______________________________________

PATIENT'S DATE OF BIRTH _______/________/______________

I HEREBY AUTHORIZE YOU TO FURNISH ANY AND ALL INFORMATION YOU HAVE REGARDING THE ABOVE PATIENT'S MEDICAL HISTORY AND PHYSICAL CONDITION, INCLUDING IMMUNIZATIONS TO:

MICHAEL TAYMOR, MD
145 N. CALIFORNIA AVE.
PALO ALTO, CA 94301
TEL: (650) 321-7722
FAX: (650) 326-7775

THANK YOU FOR YOUR COOPERATION,

YOURS TRULY,

____
(AUTHORIZING SIGNATURE)

RELATIONSHIP TO PATIENT:

_______SELF
_______MOTHER
_______FATHER
_______LEGAL GUARDIAN
_______PRIMARY CARE PHYSICIAN