



## Request to Transfer Records to Paoli Family Medicine

Please transfer medical records for those listed below to:

**Paoli Family Medicine**  
250 W. Lancaster Avenue, Suite 120  
Paoli, PA 19301  
Phone: 610-644-8069 eFax: 610-644-6736

*Please complete all fields marked with an asterisk (\*)*

\*Date Requested: \_\_\_\_\_

\*Name of Previous Practice: \_\_\_\_\_

\*Practice Phone #: \_\_\_\_\_

\*Practice Fax #: \_\_\_\_\_

\*Requestor's Name: \_\_\_\_\_

\*Date of Birth: \_\_\_\_\_

\*Signature of Requestor (Patient or Parent/Legal Guardian):

\_\_\_\_\_

\*Relationship to patient: \_\_\_\_\_

If requesting for minor(s)/child(ren):

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Additional Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Additional Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Additional Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

