Date:

PROVIDENCE Health & Services

Transfer/Continuation of Care Records Request

This form is for the purpose of transferring protected health information from a medical provider/facility to a PH&S medical provider/facility only.

Please print all information

Patient's Name: DOB:

Providence Medical Group is requesting information from the following provider and/or facility:

Provider:

Facility:

Phone: Fax Number:

Relationship to Patient: ☐ Primary Care Provider ☐ Specialty Provider ☐ Other

Documents Requested:	Time Frame Requested
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☐	
☐ Other:	

This form should not be used for release of: HIV/AIDS testing treatment, Genetic Testing, or Drug/Alcohol specific visits

Please submit the requested information to the following Providence Medical Group Clinic:

Patient/ Patient Representative Signature

Date

Patient/ Patient Representative Name

Relationship to Patient