Record Transfer Request

Date of Birth: Date:

Doctor/Hospital:

Address:

City: State: Zip Code:

Telephone:

Fax #:

I hereby Authorize the release of my MEDICAL RECORDS or copies of such and request that they be transferred to:

JOSE GONZALEZ, M.D., P.A.,

1643 LIBERTY ROAD, UNIT 106

ELDERSBURG, MD, 21784

PHONE: 410-795-4020

Fax: 420-795-2733

Patients name: Signature of Parent