FAMILY Healthcare OF LAKE NORMAN

Date:

To:

Subject: Records Transfer Request

I, _____, request the transfer of my/my child's medical records for continuity of care for (specify one):

All Dates of Service _____ Specific Dates of Service _____

Patient:

SSN: **DOB:**

Please send the records to:

Family Healthcare of Lake Norman, PC, 9718-A Sam Furr Rd., Huntersville, NC 28078.
Fax: 704 987-8221 or e-mail: **doctor@familyhealthcareoflakenorman.com**

This authorization is for one year unless specified differently. I understand I have the right to revoke this authority at any time. I also understand this information may be disclosed to those who have a need to know (i.e. medical personnel providing care or insurance carriers as required by the individual's or medical practice's contracts)

Any charge associated with this transfer may be sent to me at my current address.

Current Address:

Thank you,

Signature

(FAMILY HEALTHCARE PREFERS RECORDS BE E-MAILED (doctor@familyhealthcareoflakenorman.com) OR FAXED IF LESS THAN 15 PAGES DURING BUSINESS HOURS OR 50 PAGES AFTER BUSINESS HOURS)

9718-A Sam Furr Rd., Huntersville, NC 28078
704 987-7970 or 704 987-8221 (Fax)
Web Site: FamilyHealthCareofLakeNorman.com