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*435 North Roxbury Drive, Suite 311*

*Beverly Hills, CA 90210*

*310-657-4586*

## **REQUEST FOR TRANSFER OF MEDICAL RECORDS**

Dear Dr. \_\_\_\_\_

We now have the pleasure of caring for the following patient(s):

Child's name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Names of additional children:

\_\_\_\_\_

**PLEASE MAIL THE ENTIRE MEDICAL RECORD  
TO OUR OFFICE ADDRESS.**

Thank you.

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Parent Signature

Date