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REQUEST FOR TRANSFER IN FORM

TO: _____
 ADDRESS: _____

PLEASE FURNISH: CHILD HEALTH CARE ASSOCIATES

_____ 6700 KIRKVILLE ROAD
 EAST SYRACUSE, NY 13057
 PHONE (315) 463-2013
 FAX (315) 463-2019

_____ 8138 OSWEGO RD
 LIVERPOOL, NY 13090
 PHONE (315) 652-8800
 FAX (315) 652-8808

With records regarding my children's medical history, immunizations, growth records, lab & x-ray results, treatments, medications, allergies, and other patient information.

Please include the child's name and date of birth, and your address and telephone number on the records you send to our office. If you have any names of previous health care providers, please include them to aid us in acquiring any other records.

Child's Name: _____ DOB: _____
 _____ DOB: _____
 _____ DOB: _____
 _____ DOB: _____

Parent Signature: _____ Date: _____

Parent Name in Print: _____