



NORTHEAST  
WYOMING  
PEDIATRIC  
ASSOCIATES, P.C.

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**REQUEST FOR US TO SEND YOUR RECORDS TO ANOTHER DOCTOR**

(name of patient)\_\_\_\_\_ (date of birth)\_\_\_\_\_

(name of patient)\_\_\_\_\_ (date of birth)\_\_\_\_\_

(name of patient)\_\_\_\_\_ (date of birth)\_\_\_\_\_

(address of patient)\_\_\_\_\_

covering the following episodes of care and dates of treatment:\_\_\_\_\_

1. Information to be sent: relevant records\_\_\_\_\_ test results\_\_\_\_\_ other\_\_\_\_\_

2. Information is to be sent to:

(name)\_\_\_\_\_

(address)\_\_\_\_\_

3. Reason for sending records:\_\_\_\_\_

Signed: (patient or legal representative):\_\_\_\_\_ (date)\_\_\_\_\_

(relationship to patient)\_\_\_\_\_

It is our policy to exchange the *Minimum Necessary* Protected Health Information.