Rainbow Pediatrics

Records Transfer Request

Please complete this form and return to our New Albany office either in person or by mail to:

Rainbow Pediatrics; Attn: Medical Records; 153 West Main St., Suite 200; New Albany, OH 43054

Your records will be sent to you on a USB flash drive. The drive will contain all of the records for one child. Our charge for the transfer is **$30 per patient** and we ask that you pay in advance with a credit card provided on this request form.

If you prefer a copy of the **Vaccine Record ONLY** we will send that at **NO CHARGE**, please check here: ❑

Date of Request:_____ Name of Parent/Legal Guardian: _____

Best contact number: _____E-mail Address: _____

Patient(s) & Date of Birth(s):_____

Requested Records can take 30 days to process and will be mailed to your address.
Please provide your current address:

_____

Please Identify Reason(s) for Transfer:

____Age (over 22; therefore seeking services other than Pediatrician)
____Change of insurance carrier to:_____
____For specialist review; not transferring out of practice
____Moving out of the area
____Other (please elaborate):_____

_____
Signature Parent/Legal Guardian

Please provide payment information below:

Cardholder Name (Printed): _____

❑ Mastercard ❑ Visa ❑ American Express ❑ Discover

Card Number: _____

Exp. Date: _____ Security Code: _____ Amount to be charged: _____

Cardholder's Signature: _____

Billing Address for the card: _____

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