



Request for Transfer of Medical Records

Date: _____

I, _____, authorize the transfer of my (child's) medical records to another Pediatric Alliance office as selected below:

Allergy Division
Arcadia Division
Chartiers/McMurray Division
Endocrinology Division
Fox Chapel Division

Greentree Division
North Hills Division
Northland Division
Southwestern Division
St. Clair Division

For the following children:

Full Name

Date of Birth

Print Name of Parent or Legal Guardian:

Signature of Parent or Legal Guardian:
