INTEROFFICE RECORDS TRANSFER FORM

By signing below, I authorize the Transfer to the listed patient's medical records from the provider listed below to the circled provider.

Physician you are transferring from: _____

Reason for transfer: _____

PLEASE CIRCLE THE PHYSICIAN YOU REQUEST TO TRANSFER TO :

MACON OFFICE

Jason L. Smith, MD Lance E. Slade, MD Chris J. Cawley, MD

Donna M. Payne, MD Gabriella R. Kacsoh, MD

WARNER ROBINS OFFICE

Robert A. Ford, MD Jessica T. Ford, MD

Jill M. Waters, MD Audrey J. Maddox, MD

BONAIRE OFFICE

Truitt S. Boatright, MD R. Kimberly Coker, MD

FORSYTH OFFICE

Lindsay S. Kinnebrew, MD

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

_____
Parent/Guardian Signature
____/____/_____
Date Signed

_____
Relationship to Patient

(_____) _____
Contact Number

_____
Physician Signature
____/____/_____
Date Signed

_____
Physician Signature
____/____/_____
Date Signed

** **This Transfer has to be approved by both Physicians and may take up to 30 days for completion**