HIP®
HEALTH PLAN OF NEW YORK

Medical Records Transfer Request

Please **complete and sign the form below and return it to your former medical group** so that your medical record and x-rays and/or those of your family members can be sent to the new medical group.

Each adult (18 and older) family member should sign on a separate line for the release of his/her medical records. Either parent may sign for release of records for minor (under 18) children, indicating the full name of the minor child.

It is most important that you complete and sign this release so that your new medical group will have your medical history readily available when you receive care.

Medical records are confidential documents. We will only transfer records after this consent form has been completed and signed.

I hereby request and authorize the Date ____________________

(Fill in name of former Medical Group and address)

TO RELEASE TO

______________________________ ______________________________
Medical Group Medical Group

______________________________ ______________________________
Address Address

The complete medical records in your possession for myself and/or members of my family

Subscriber: ______________________________
(print name then sign full name)

____
Signature

Spouse: ______________________________
(print name then sign full name)

____
Signature

HIP ID Number	Home Address
Telephone Number	City, State, Zip Code

NOTE: EACH & EVERY DEPENDENT 18 AND OVER MUST **PRINT** AND **SIGN** FULL NAME:

Dependent (Print full name)	Signature (if over 18)
Dependent (Print full name)	Signature (if over 18)
Dependent (Print full name)	Signature (if over 18)
Dependent (Print full name)	Signature (if over 18)
Dependent (Print full name)	Signature (if over 18)

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