South Island Gastroenterology Associates, PC
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Record Transfer Request

Date:______________________

Patients Name:______________________ Patients Date of Birth:__________

I hereby authorize South Island Gastroenterology Associates, PC to release my medical records and/or copies of such, and request that they be transferred :

To:_______________________________

Address:____

City:_______________________ State:__________ Zip:_____________

Phone:______________________ Fax:____________________________

_____________________________ _____________________________
NAME OF PATIENT (print name) SIGNATURE OF PATIENT or REPRESENTATIVE