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CONSENT FOR MEDICAL RECORDS TRANSFER

Date: \_\_\_\_\_

Dear Dr. \_\_\_\_\_

Please transfer the Medical Records for the following patients:

NAME	PLEASE PRINT	DATE OF BIRTH
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Phone Number \_\_\_\_\_

Permission is hereby granted for release of my medical records to the physicians of

LMG FAMILY PRACTICE  
 LANSDALE OFFICE  
 1019 SOUTH BROAD STREET  
 LANSDALE PA 19446  
 215-361-5090

\_\_\_\_\_  
 Signature of Responsible Party

Blue Bell Office  
 1379 Skio-pack Pike  
 Blue Bell, PA 19422  
 Phone 610.272.9400  
 Fax 610.272.9427

Lansdale Office  
 1019 S. Broad Street  
 Lansdale, PA 19446  
 Phone 215.361.5090  
 Fax 215.412.4296

Highpoint Square Office  
 1500 Horizon Drive, Suite 102  
 Chalfont, PA 18914  
 Phone 215.712.2500  
 Fax 215.997.2307