Horizon Blue Cross Blue Shield of New Jersey

TRANSFER OF MEDICAL RECORDS

If you wish to have medical records transferred from your previous or present physician, please fill out the Information below (please print clearly).

To: _____

Name of previous or present doctor or hospital

ADDRESS: _____

_____

_____

I hereby authorize and request you to release to:

PHYSICIAN NAME: _____

ADDRESS: _____

_____

_____

The following medical records for the period on or about: _____

☐ Complete Medical Record

☐ Other (please specify) _____

PATIENT NAME: _____

ADDRESS: _____

_____

_____

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY #: _____ – _____ – _____
Month Day Year

AUTHORIZATION: _____ DATE: _____

PARENT OR GUARDIAN SIGNATURE

An Independent Licensee of the Blue Cross and Blue Shield Association