

# Record Transfer Request



P.O. Box 270  
Myersville, MD 21773  
301-293-3456

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

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

Please send copies of all records and x-rays for the following patients to the address above.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

Thank you,