TOUCHPOINT
PEDIATRICS, P.A.

DATE: _____

TO: _____

_____

_____

RE: **TRANSFERRING MEDICAL RECORDS**

CHILDREN'S NAME(S)	DATE OF BIRTH	CHILDREN'S NAME(S)	DATE OF BIRTH

PLEASE TRANSFER ALL MEDICAL RECORDS INCLUDING IMMUNIZATIONS, LABS, HOSPITAL RECORDS, SPECIALIST'S REPORTS AND PAST/PRESENT NOTES TO:

DR. JENNIFER SHAW-BRACHFELD
AND ASSOCIATES
TOUCHPOINT PEDIATRICS, P.A.
17 WATCHUNG AVENUE
CHATHAM, NJ 07928
FAX. 973.665.0901

Any faxes greater than fifty (50) pages, please fax after 4:00 pm.
If there are any concerns, please contact the office.

THANK YOU FOR YOUR HELP WITH THIS MATTER.

_____
SIGNATURE OF PARENT

ADDRESS: _____

_____

_____

TEL: _____

REV. 10.23.17