



Rainbow Pediatrics
Records Transfer Request

_____ 6905 Hospital Drive
Suite 100
Dublin, Ohio 43016
614.791.2000
Fax: 614-939-2201

_____ 153 W. Main Street
Suite 200
New Albany Ohio 43054
614.939.2200
Fax: 614-939-2201

There is a \$10.00 charge per patient that will need to be paid via credit card before the transfer can be completed. Please provide a phone number we can call to obtain payment. After receiving payment our medical records clerk will create an electronic file(s) of your child's medical records and password protect the file(s). You will receive two(or more) separate e-mails, one containing the password and one or more containing the medical records. Please specify if your records are, or include dates, from before 2007.

Date of Request: _____

Name of Parent/Legal Guardian: _____

Phone Number to call for payment: _____

Patient(s) & Date of Birth(s): _____

Request Records to be forwarded to:

E-mail Address: _____

Please Identify Reason(s) for Transfer:

- ____ Age (over 22; therefore seeking services other than Pediatrician)
- ____ Change of insurance carrier to: _____
- ____ For specialist review; not transferring out of practice
- ____ Moving out of the area
- ____ Other (please elaborate): _____

If moving, please provide us with your new address:

Signature Parent/Legal Guardian

If you prefer a paper copy the following rates will apply and processing will take up to 30 days from receipt of payment.

- Medical Records are legal documents, therefore owned by Rainbow Pediatrics. Charges for copies of medical records are in accordance with Ohio Code Section 3701.74 which states:
- \$3.07 per page for the first 10 pages
 - \$0.64 per page for pages 11-50
 - \$0.26 per page for pages 50 and higher
 - Postage incurred by health care provider or medical records company