

# Vista Healthplan™ Medical Records Transfer Request

Please **complete and sign the form below and return it to your former Physician** so that your medical record and x-rays and/or those of your family members can be sent to the current Physician.

Each adult (18 and older) family member should sign on a separate line for the release of his/her medical records. Either parent may sign for release of records for minor (under 18) children, indicating the full name of the minor child.

It is most important that you complete and sign this release so that your new Physician will have your medical history readily available when you receive care.

Medical records are confidential documents. Your Physician will only transfer records after this consent form has been completed and signed.

**I hereby request and authorize**

Date \_\_\_\_\_

(Fill in name of former Primary Care Physician and address)

\_\_\_\_\_  
Physician (Former)

\_\_\_\_\_  
Address

**To release the complete medical records in your possession for myself and/or members of my family to:**

\_\_\_\_\_  
Physician (Current)

\_\_\_\_\_  
Address

Subscriber: \_\_\_\_\_  
(print name then sign full name)

Spouse: \_\_\_\_\_  
(print name then sign full name)

\_\_\_\_\_  
Signature:

\_\_\_\_\_  
Signature:

Vista Healthplan™ ID Number

Home Address

Telephone Number

City, State, Zip Code

**NOTE: EACH & EVERY DEPENDENT 18 AND OVER MUST PRINT AND SIGN FULL NAME:**

Dependent (Print full name)

Signature (if over 18)

Dependent (Print full name)

Signature (if over 18)

Dependent (Print full name)

Signature (if over 18)

Dependent (Print full name)

Signature (if over 18)

Dependent (Print full name)

Signature (if over 18)