



## Request for Transfer of Records

I hereby authorize: \_\_\_\_\_

Medical Practice Name

\_\_\_\_\_  
Telephone #

\_\_\_\_\_  
Fax #

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

To release medical records, including immunizations and growth curves, for:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

To: Acorn Pediatrics, LLC  
280 W Kagy Blvd  
Suite G  
Bozeman, MT 59715  
Phone 406-522-KIDS (5437)  
**Fax 406-522-1536**

Susan M. Daniels, MD  
Sheila M. Idzerda, MD  
Kathryn M. Lowe, MD  
Tory Katz, MD  
Christine R. Hodgson, C-PNP  
Lynne Foss, C-PNP

By signing this authorization I give permission to release and transfer my child's protected health information to the above requesting doctor for the purpose of treatment. I understand that this authorization is in effect for one year from the date signed.

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Relationship to Patient**

Thank you.