

AUTHORIZATION FOR FAMILY HEALTH CENTER TRANSFER

PRESENT FAMILY HEALTH CENTER:

Beckwith Family Health Center	Jenison Family Health Center	Wyoming Family Health Center
Rockford Family Health Center	Walker Family Health Center	

REQUESTED FAMILY HEALTH CENTER FOR TRANSFER:

Beckwith Family Health Center	Jenison Family Health Center	Wyoming Family Health Center
Rockford Family Health Center	Walker Family Health Center	

Please list all Family Members that are to be transferred:

Full name of member	Date of birth
Full name of member	Date of birth
Full name of member	Date of birth
Full name of member	Date of birth
Full name of member	Date of birth
Full name of member	Date of birth

Reason for Transfer

<input type="checkbox"/> Closer to Home	<input type="checkbox"/> Closer to Work	<input type="checkbox"/> Dissatisfied with Practitioner
<input type="checkbox"/> Dissatisfied with Overall Service	<input type="checkbox"/> Preferred Hours of Operation	<input type="checkbox"/> Other _____

I am authorizing the above family members transfer of Family Health Center. I also understand that the above family members medical records will not be transferred until the 1st of the month following the signature date.

Patient's or (Representative's Signature)	Date
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