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MEDICAL RECORDS REQUEST FORM

This form will serve to transmit the named patient's medical record created by Peter N Sotos, M.D. into the patient's guardianship. Once transmitted, Peter Sotos, M.D. is absolved of responsibility for maintaining the record for that patient.

Patient NAME: _____ DATE: _____
(please print name legibly)

FEE:
\$0 (Before April 24, 2015)
\$10 (after April 24, 2015)

ADDRESS: _____

PHONE: _____

DATE OF BIRTH: _____

SIGNATURE:

_____ (patient)

_____ (guardian, relationship, name)
(print)

_____ guardian signature