MEDICAL RECORDS TRANSFER REQUEST

Patient Name: ______________________________

Date of Birth: ______________

Address: __________________________________

City: ____________________ State:____________Zip: _________

Phone: ___________________

Name of Parent, Guardian or Legal Representative:

____

- **Please transfer the medical records for the patient noted above to:**

  - **Patient**
  - **Dr. Maz Kazahaya, M.D.**
    1619 North 9th St.
    Stroudsburg, Pa. 18360
    Fax (570) 422-1010
  - **Dr's Office or Other Facility**
    Dr's Name __________________ Fax: _____________

________________________ Date: ____________

Signature of Patient, Parent or Legal Representive