Telephone (585) 342-5665
Fax (585) 342-2345

Practice Limited to Pediatrics

PORTLAND PEDIATRIC GROUP, LLP

JOHN R. BOSCO, M.D., FAAP
RODERICK G. DAVIS, M.D., FAAP
MICHAEL J. HOLMES, M.D., Ph.D., FAAP
CHAD B. PRESTON, M.D., FAAP
JOANNE P. CORDARO, M.D., FAAP
SHERRY W. SMITH, M.S., P.N.P.
1700 Hudson Ave
Rochester, N.Y. 14617

Please transfer the records of the following patient(s):

_______________________________________ DOB _____________

_______________________________________ DOB _____________

_______________________________________ DOB _____________

_______________________________________ DOB _____________

Cared for at Portland Pediatric Group from ______________ to __________________

To my/our new physician

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These records include: Please check ONE

___All medical information available in the chart including psychiatric history, mental illness history, drug use or abuse history, and information including any sexual status or history.

___Only medical history, EXCLUDING: psychiatric history, history of drug use, and history of sexual contacts and conduct.

___Other:____

Signature of (check one) ___patient ___parent ___legal guardian

____

Date________________________