Covenant Medical Center, P.C.

RECORDS TRANSFER REQUEST

Date:_____

To:_____
(Doctor/Hospital)

Address: _____

City: _____ **State:**_____ **Zip:**_____

Telephone: **(____)**_____

I hereby authorize the release of my medical records or copies of such and request that they are transferred to:

Cecilia O. Babalola, MD
5014 Stone Mountain Hwy., Suite C
Lilburn, GA 30047
Phone (770) 564-6900 Fax (770) 564-6030

Patient Name: _____

Guardian Name : _____
(If other than patient)

Patient/Guardian Signature: _____

Date: _____