Provider / Physician List

Patient Name: ______________________________ Date of Birth:____________

I request and authorize 1 CP Place PLLC to transfer or obtain healthcare information of the patient named above to/from:

Specialty: ☐ Birth/NICU ☐ Neurologist

☐ Pediatrician ☐ Other: _____________

Physician/Clinic: ____________________________

Address: ________________________________

____

Phone: _________________________________

Fax: ___________________________________

Specialty: ☐ Birth/NICU ☐ Neurologist

☐ Pediatrician ☐ Other: _____________

Physician/Clinic: ____________________________

Address: ________________________________

____

Phone: _________________________________

Fax: ___________________________________

Specialty: ☐ Birth/NICU ☐ Neurologist

☐ Pediatrician ☐ Other: _____________

Physician/Clinic: ____________________________

Address: ________________________________

____

Phone: _________________________________

Fax: ___________________________________

Specialty: ☐ Birth/NICU ☐ Neurologist

☐ Pediatrician ☐ Other: _____________

Physician/Clinic: ____________________________

Address: ________________________________

____

Phone: _________________________________

Fax: ___________________________________

Specialty: ☐ Birth/NICU ☐ Neurologist

☐ Pediatrician ☐ Other: _____________

Physician/Clinic: ____________________________

Address: ________________________________

____

Phone: _________________________________

Fax: ___________________________________

Specialty: ☐ Birth/NICU ☐ Neurologist

☐ Pediatrician ☐ Other: _____________

Physician/Clinic: ____________________________

Address: ________________________________

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Phone: _________________________________

Fax: ___________________________________

Version 2017-01-06