Your Partners in Pediatric & Adolescent Care!
PEDIATRIC PARTNERS, P.A.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the release of information from the medical record of:

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Please Release Information To:

Name: _____
Address: _____
City/State/Zip: _____
Telephone: _____
Fax: _____

Information to be Released:

☐ Immunization Record/Growth Chart/Last Well Visit
☐ Labs/X-Rays

Reason for Release of Information:

☐ Change of Physician ☐ Personal Use ☐ Attorney / Legal
☐ Change of Insurance Please specify your new carrier: _____

Informed Consent for Release of Confidential Information.

I understand that once I have requested the transfer of records our relationship with Pediatric Partners will be terminated. Any questions, concerns or need for care will be directed to your new physician.
I understand that I may revoke this consent in writing at any time.
I understand that this consent will expire 90 days after the date of my signature unless otherwise specified.
I understand that there is a fee for copy services rendered.
I understand that this information may include HIV/AIDS, mental health and chemical dependency diagnosis, treatment, and test results.
I understand that the information released is for the specific purpose stated above.
I understand that my medical records may contain reports only a physician can interpret.
I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.
I will not hold Pediatric Partners liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient

Request Received: _____ Payment Received: _____ Records Sent: _____