Records Release Authorization
Transferring **From** Winghaven Pediatrics

Parent/Guardian: _____Telephone Number: _____

I hereby authorize the use of disclosure of my child/children's health information as described below.

Patient's Name: _____ DOB: _____
Patient's Name: _____ DOB: _____
Patient's Name: _____ DOB: _____
Patient's Name: _____ DOB: _____

Please state the reason for requesting medical records:

_____

(Ex: changing physicians, moving, own use, insurance purpose, etc.)

We will fax or e-mail your child's medical record to your new provider in one week at no charge, (If you need them sooner than one week, there will be a charge of $1.00 per page).

WingHaven Pediatrics is authorized to release medical records to the following

_____

Doctor or Medical Center (print)

Address:

_____

_____

Telephone Number: _____ **Fax Number:** _____

This authorization shall be in force and effect for 90 days from date signed (unless otherwise noted) at which time authorization to use or disclose expires. I understand I have the right to revoke this authorization at anytime, in writing, or by mailing notification to this practice.

Parent/Guardian Signature: _____ **Date:** _____

Parent e-mail address: _____

Office use only: