PEDIATRIC PARTNERS LLC

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There is a $20 fee for records

AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

Patient name: _____ **DOB:** _____

Patient name: _____ **DOB:** _____

Patient name: _____ **DOB:** _____

Patient name: _____ **DOB:** _____

Address: _____

Telephone: _____

I hearby authorize Pediatric Partners LLC to: Release Obtain (Circle one)

Name of practice: _____

Practice address: _____

Practice phone: _____ **Fax:** _____

Records authorized to be released/obtained:

- ☐ Complete health record
- ☐ Last 3 physical exams, vaccination records, growth charts, ALL office visits, lab & diagnostic tests, and correspondence in the past 24 months
- ☐ Medical summary, vaccination records, growth charts, and most recent physical exam
- ☐ Hospital reports: Specify date(s): _____
  - ☐ Admission H&P ☐ Discharge summary ☐ ER visit ☐ Lab & diagnostic tests
- ☐ Outpatient reports (ie. Specialists)
- ☐ Urgent care
- ☐ Other: _____

Reason for transfer: **(ie: Moving, continuity of care, etc)**

_____

I understand the requested information may contain protected health information related to mental health, developmental disabilities, substance abuse, sexually transmitted diseases, and HIV testing. I understand that the released information may be re-disclosed upon written authorization to Pediatric Partners LLC to disclose medical information. I understand I may revoke this authorization in writing at any time.

Patient/Guardian name printed: _____

Relationship to patient: _____

Signature: _____ **Date:** _____

Expires 12 months from date

DON'T FAX RECORDS CONTAINING MORE THAN 10 PAGES

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