HIPAA COMPLIANT MEDICAL RECORD TRANSFER FORM

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This form can be signed and then emailed to: forms@allstarpeds.com

Please allow up to 30 days for processing

PLEASE PRINT

Step 1: Patient Name: _____ Date of Birth: _____

Address_____
Street City State Zip Code

Mobile Phone #_____ Email address: _____

Step 2: (Please check one) I hereby authorize All Star Pediatrics to release ☐ **OR** obtain ☐ my health information

FROM/TO:

Name of Physician/Medical Facility_____

Address: _____
Street City State Zip Code Phone # Fax #

Step 3: Reason for disclosure of records

- ○ Transfer of care
- ○ Other (please specify) _____

All Star Pediatrics sends the following records for the appropriate age group:

- **For children under 14 we send the entire chart**
- **For children over 14 we send the last 2 years of records and immunizations (Additional records can be made available upon request.).**

Step 4: PLEASE INCLUDE THE FOLLOWING INFORMATION IN THE RELEASE OF RECORDS: (check all that apply)

☐ ALCOHOL/DRUG TREATMENT ☐ MENTAL HEALTH INFORMATION
☐ GENETIC TESTING ☐ HIV-RELATED INFORMATION

Unless the above specific information is checked ☑ to be released, in most instances it will be redacted from the records sent

Step 5: I WOULD LIKE TO RECEIVE THE INFORMATION VIA (check one)

*** Please note records will not be released until payment is received.**

□ Please upload my records my All Star intellichart portal – **$25**
□ Please fax my records to my new provider – **$25**
(I understand that some receiving offices cannot accept large faxes. In this case, a representative from All Star will reach out and assist in finding an alternative method)
□ Please print my records and I will pick them up at the office – entire chart **$35 ;** immunizations/last well visit **$15**
□ Please copy my records to a USB drive and I will pick them up at the office - **$35**

Step 6: Signature(s)

I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I understand that signing this form is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State privacy regulations. A copy of this authorization has been provided. This authorization is **valid for 90 days** for the release of information as indicated by date of signature below.

_____ _____ _____

Patient Signature (If over 18yrs)/Guardian Signature *Date* *Relationship to patient*

I authorize the release of mental health records, psychiatric/psychotherapy records, and drug/alcohol information or treatment under the same terms and conditions. (**Patients over the age of 14 must sign below, not parents/guardians**)

_____ _____ _____

Patient Signature (if over 14yrs)/Guardian Signature *Date* *Relationship to patient*