



702 GORDON DRIVE • EXTON, PENNSYLVANIA 19341
(610) 363-1330 • (610) 524-8574

SPECIALIST RECORDS TRANSFER REQUEST

PLEASE PRINT

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

Step 2: I hereby authorize All Star Pediatrics to release my health information **TO:**

Name of Authorized Entity/Specialist _____

Step 3: I am authorizing release of information to the following: (Please check all that apply)

- | | | |
|--|--|---|
| ☐ Immunizations | ☐ All Hospital/Urgent Care/ER Records | ☐ Lab Results |
| ☐ Medication List | ☐ Colonoscopy | ☐ Progress Notes |
| ☐ Growth Chart | ☐ All Imaging | ☐ All Consults |
| ☐ Problem List/Diagnosis List | | ☐ All Chart Messages |

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 |

Step 5: Purpose for disclosure is at the request of the individual based on the following:

- | | |
|---|---|
| ☐ Continuity of Care | ☐ Other Reason (Please specify): _____ |
|---|---|

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 365 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