San Diego Uptown Pediatrics

3500 5th Avenue, Suite 101
San Diego, CA 92103
Tel: (619) 295-3911
Fax: (619) 295-4356

Transfer of Medical Records from San Diego Uptown Pediatrics

Patient Name _____Date of Birth _____
Patient Name _____Date of Birth _____
Patient Name _____Date of Birth _____
Patient Name _____Date of Birth _____

By signing this form, I hereby authorize the release of protected health information of the above-named patient(s),

FROM:
San Diego Uptown Pediatrics Medical Group
3500 5th Avenue, Suite 101
San Diego, CA 92103
Tel (619) 295-3911
Fax (619) 295-4356

TO:
Name of Practice or Physician_____
Street Address_____
City_____State_____ZIP_____
Tel_____Fax_____

Please provide the following information:
▢ Entire medical record ▢ Records from date(s) _____ to _____
▢ Immunization record only
▢ Other (please specify) _____

The information will be used for the following purpose:
▢ Continuity of medical care
▢ Other (please specify)_____

PURPOSE OF DISCLOSURE: San Diego Uptown Pediatrics uses this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This form summarizes the anticipated use of information regarding your child for which this authorization is required. You have the right to revoke this authorization at any time prior to the practice's compliance with the request set forth herein. Such a revocation shall not affect any disclosures that have already been made due to your prior authorization. This authorization expires upon San Diego Uptown Pediatrics' release of the information described above or ninety (90) days after the Date of Authorization, whichever comes first.

I hereby acknowledge receipt of a copy of this Authorization.

Printed Name_____Relationship to Patient_____

Signature_____Date_____