



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

**Transfer of Medical Records to 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:**

Name of Practice or Physician \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Tel \_\_\_\_\_ Fax \_\_\_\_\_

**TO:**

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

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, provided that the revocation is in writing. However, such a revocation shall not affect any disclosures that have already been made due to your prior authorization. This authorization expires upon the 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 \_\_\_\_\_