Forest Hills Pediatric Associates, PC

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name:____ Date of Birth____________________

☐ My family is transferring out effective _____________, please transfer my child's medical record from Forest Hills Pediatric Associates, PC to the physician listed below: (enter date above)

☐ We are only seeking a consultation. Please send a copy of my child's medical record from Forest Hills Pediatric Associates, PC to the following consultant:

Release to: ____
Name

____
Address

____
City State Zip

Forest Hills Pediatrics Associates, PC will continue to provide emergency care for 30 days following a transfer request.
ALL SCHEDULED VISITS WILL BE CANCELLED.

Medical Information to be sent:

Check the box **AND** circle or highlight "including" or "excluding" to state what records are needed.

☐ Entire Medical Record (*INCLUDING or* EXCLUDING) information related to the treatment for substance abuse or dependency; psychiatric
(circle to select one above)
or mental health treatment: information related to testing or treatment of HIV/AIDS.

☐ Record of care from _________ to _________ (*INCLUDING or* EXCLUDING) information related to treatment for substance abuse or
(enter dates above) (circle to select one above)
dependency; psychiatric or mental health treatment; information related to testing or treatment of HIV/AIDS.

☐ Other (specific records being requested): ____

____

I authorize medical information to be released as indicated above. I understand this release is effective for 6 months from the date of execution, but that I may revoke my consent at any time by providing written consent to the above-named party.

____
Patient (18years and older) or Patient's Legal Guardian Signature

____
Relationship to Patient

____
Phone Number

____
Date

____
Witness

____
Date