Forest Hills Pediatric Associates, PC

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth_____

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

☐ 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

Medical Information to be sent:

☐ Entire Medical Record, *INCLUDING* information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment: information related to testing or treatment of HIV/AIDS.

☐ Entire Medical Record, *EXCLUDING* information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment: information related to testing or treatment of HIV/AIDS.

☐ Record of care from _____ to _____ *INCLUDING* information related to treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of HIV/AIDS.

☐ Record of care from _____ to _____ *EXCLUDING* information related to treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of HIV/AIDS.

☐ If deemed necessary by Doctor_____, I authorize this information to be sent via fax transmission.

Other_____

_____

☐ PLEASE CANCEL ALL UPCOMING APPOINTMENTS

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 Relationship to Patient

_____ _____
Phone Number Date

_____ _____
Witness Date