AUTHORIZATION FOR PEDIATRIC PARTNERS TO RELEASE CONFIDENTIAL PATIENT INFORMATION

Patient Name _____

DOB: _____ Telephone Number: _____

I HERBY AUTHORIZE PEDIATRIC PARTNERS TO RELEASE MEDICAL INFORMATION TO:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

PLEASE INDICATE THE REASON YOU ARE REQUESTING MEDICAL RECORDS TO BE RELEASED:

- ☐ Moving (out of state or area)
- ☐ Referral to specialist (continuity of care)
- ☐ Transitioning to Adult/PCP specialist
- ☐ Choosing not to vaccinate
- ☐ Unhappy with practice (Please state why): _____
- ☐ Switching Practices (please state why): _____
- ☐ Other reason (Please state): _____

PLEASE INDICATE THE SPECIFIC INFORMATION TO BE RELEASED:

- ☐ Complete Medical Record
- ☐ Physical Exams and Growth Charts
- ☐ Immunization Record

I understand and agree that I am financially responsible for the following fees associated with my request for medical records.

Complete Medical Record - There is no charge for medical records that are sent to another PCP or specialist. If you prefer medical records be mailed to you directly it will be sent on a CD, the cost is $40.00. *Please allow up to 30 business days for processing.

PLEASE INDICATE HOW YOU WOULD LIKE TO RECEIVE YOUR MEDICAL RECORDS:

- ☐ I'm requesting medical records to be sent to the provider listed above
- ☐ I'm requesting to pick up medical records on a CD at the office
- ☐ I'm requesting medical records on a CD to be mailed directly to me.

Any information including diagnosis and records of any treatment or examination rendered to me including any Federal and State protected information under appropriate statute, Mental Health, Psychotherapy, Substance Abuse, Human Immunodeficiency Virus (AIDS) tests results and treatment. I understand that this authorization will remain in effect for six (6) months or until I revoke it in writing to an authorized employee of Pediatric Partners. I have read Pediatric Partners' Notice of Privacy. I hereby release Pediatric Partners and its employees from any and all liability that may arise from the release of information as I have directed.

_____ _____

Signature of Patient Date

_____ _____ _____

Signature of Empowered Representative Relationship to Patient Date