AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

PLEASE NOTE: COPY FEE WILL BE CHARGED FOR MEDICAL RECORDS

RECORDS WILL NOT BE FAXED

COMPLETE FORM FOR EACH CHILD

PATIENT NAME:_____DATE OF BIRTH:_____

Authorizes Primary Pediatrics to release medical records to:

FACILITY NAME:_____

ADDRESS:_____

CITY, STATE, ZIP:_____

FACILITY PHONE:_____

Reason for transferring (**circle one**): Change Insurance Patient Move Dissatisfaction

Other:_____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome or human immunodeficiency virus. It may also include information about behavioral or mental health services and treatment for alcohol or drug abuse. Only medical records originated through this facility will be copied.

This authorization will expire one year after the date signed.

I have read the above Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

Signature of Patient/Parent/Authorized Representative Date

_____ _____

Printed Name of Authorized Representative Relationship to Patient