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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS for TRANSFER OF CARE

Patient Name: ____ **Date of Birth**: __________________________

The purpose for release is to transfer care to another provider as of __/___/___
Do you plan to keep any upcoming appointments? No Yes, appointment date / /
Records to be delivered directly to:
□ Healthcare provider *Medical records faxed to a new provider is free of charge.*
□ Patient/Parent
Name of recipient: ____

Address of recipient: ____

Phone: ___________________________ Fax: ____________________________

This signed release of records for the purpose of transferring care to another provider, means Children's Medical Group, LLC will no longer be responsible for this patient's acute or well child care on the effective date of transfer.
Requested Information:
□ Concise Medical Records: ***This option most commonly satisfies required information needed by other medical practices.*** This includes: immunization record, growth chart (under age 21), medical & family history, allergies, problems, medications, recent or pertinent lab or imaging reports, and specialist notes. **Prior to release, the medical records are reviewed by the primary care provider who determines what I appropriate to include.**

- □ faxed – free of charge
- □ printed – must be paid in advance (65¢ fee per page plus postage)
- □ on disk – must be paid in advance ($10 plus postage)

□ Other Medical Records (please specify dates or request):

____

Processing records can take up to 30 days, therefore please provide adequate notice.

I. This form serves the purpose of a general authorization for the release of protected health information and a specific authorization for the release of information protected by state and federal confidentiality laws and regulations. The information to be released may contain information pertaining to psychiatric, psychological, drug and/or HIV or AIDS testing, diagnoses or treatment.

II. I understand my right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and submit this to Children's Medical Group. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire upon the earlier of 60 days from today's date or a specific date, event or condition to such revocation.

III. I understand authorizing the disclosure of this health information is voluntary. I need not sign this authorization to ensure treatment, payment or healthcare operations. I understand I may inspect/copy the information to be used or disclosed according to state and federal law, and as stated in the Privacy Notice of this facility. I understand information once released from this facility may not be protected by federal confidentiality rules and carries with it the potential for an unauthorized re-disclosure.

____ _____________________________________
Print Name Relationship to Patient

____ _____________________________________
Signature of Patient or Legal Representation Date