ENGLISH ROAD PEDIATRICS & ADOLESCENT MEDICINE, LLC

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AUTHORIZATION FOR RELEASE of MEDICAL RECORDS

PURPOSE OF THIS REQUEST:

☒ I **am** transferring care to Dr.: ______________________________

Reason: ______________________________

I authorize ENGLISH ROAD PEDIATRICS to:

☐ **SEND** My Medical Records to:

☐ **OBTAIN** My Medical Records from:

Practice/Physician's Name: ______________________________

Address: ______________________________

City: ____________________ State: __________ Zip Code: __________

Phone: ____________________ Fax: ____________________

I authorize the release of copies of the following medical records, if such information exists:

SPECIFIC INFORMATION AUTHORIZED (select one or more as appropriate):

☐ Assessments
☐ Progress Notes
☐ Laboratory Test Results: ______________
☐ Diagnostic Impression
☐ Discharge Summary
☐ Diagnostic Test Results: ______________
☐ Treatment Plans
☐ Educational Information
☐ Other: ______________
☐ Immunizations
☐ Treatment summary (include history/physical, laboratory tests & x-ray reports)
☐ Entire copy of the inpatient/outpatient record checked above.

This information may be released by:

☐ Copy ☐ Court Testimony ☐ Electronic Means ☐ Verbal Means ☐ Fax

I understand that:

♦ This authorization will expire one year from the date above unless otherwise stated.
♦ I may cancel this authorization at any time by submitting a written request to the English Road Pediatrics address above, except where a disclosure has already been made in reliance on my prior authorization.
♦ There may be a charge for the request of copies of medical record information.

By signing below, I acknowledge that I have read and understand this Authorization.

Patient Name: ______________________ D.O.B: ____/____/______ SEX: M / F

Address: ______________________ City/State/Zip Code: ______________________

Cell: (____) _____-_______; Phone Number: (____) _____-_______; Email: ______________________

INSURANCE COVERAGE: ______________________ **POLICY #:** ______________________

Signature of Patient, **if 12+ years of age**: ______________________ Date: ____/____/_____

Parent/Guardian's Signature: ______________________ Relation to Patient: ______________