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:

Physician's Name: ______________________________

Practice's Name: ______________________________

Address: ______________________________

City: ____________________ State: __________ Zip Code: __________

Phone: ____________________ Fax: ____________________

This request includes the medical records summary, which includes immunizations, medication lists, allergies, growth charts, physicals, recent office visits, labs, x-rays, specialist reports. This may also include information relating to mental health, alcohol/drug treatment, and confidential HIV/AIDS information.

Additional items requested: ______________________________

Exceptions, if any: ______________________________

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: ____/_____/____ Gender: M/F/Other

Address:____________________ City/State/Zip Code:____________________

Phone: (____) _____-_______; Email: ____________________

INSURANCE COVERAGE: ____________________ **POLICY #:** ____________________

Signature of Patient, **if 18+ years of age**: ____________________ Date: ____/____/_____

Parent/Guardian's Name (Print): ____________________ Date: ____/____/_____

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