ENGLISH ROAD PEDIATRICS & ADOLESCENT MEDICINE, LLC

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AUTHORIZATION FOR RELEASE of MEDICAL RECORDS

PURPOSE OF THIS REQUEST:

[X] 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: _____