The Pediatric Center

Medical Records Release

To Send Our Patient Records to a New Provider

*Provider includes New Practice, Specialist, Hospital, Patient, Etc.

Please complete the following information:

Patient(s) Name: _____

Patient(s) DOB: _____

Patient(s) Phone number: _____

I, _____, the parent or guardian authorize the records of my child(ren), to disclose/release the following information (Check all that apply):

- ☐ Immunization Records
- ☐ Clinical Records
- ☐ Laboratory/Pathology Records
- ☐ X-ray/Radiology Records
- ☐ Billing Records
- ☐ Psychotherapy

Check One:

☐ **Pick-up at**: ☐ JR ☐ VCC ☐ LAB ☐ **Mail** ☐ ****Fax** (Up to 10 pages)

Send Records **FROM** The Pediatric Center **TO** the Following address:

Name: _____
Address: _____
_____
Phone: _____
****Fax:** _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of Patient or Patient's Representative **Date**

_____ _____
Printed name of patient representative **Representative's authority to sign for patient**

For Office Use Only

Date Received: _____ By: _____ Office Location: _____

Date Picked Up: _____ Date Scanned: _____ Date Faxed: _____ Completed By: _____

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