Request for Release of Medical Records

Patient Name: _________________________________ Date of Birth: _____________ Phone #: ___________________

Purpose of Disclosure:

✈ Transferring to another physician ❑ Referral to specialist ❑ Other: _______________________

If Transferring Out of Our Office to Another Doctor, Please Indicate the Reason:

✈ Transferring to Adult Medicine ❑ Insurance Issue ❑ Moving: New Address: ___________________________________

✈ Other (please specify): ________________________________ ___________________________________

I authorize Legacy Pediatrics to disclose the following protected health information *(select 1 box only)*

✈ Medical Record Summary including immunizations, growth charts, allergies, medications, problem list, past medical, family, and social history, and the last 3 years of office visits, physicals, labs, x-rays, and specialist reports (which may include information relating to mental health, alcohol/drug treatment, and/or confidential HIV/AIDS information)

✈ Complete Medical Records (which may include information relating to mental health, alcohol/drug treatment, and/or confidential HIV/AIDS information)

✈ Complete Medical Records with the following exceptions (please specify): ______________________________

✈ Other (please specify): ____

Method of Delivery (please allow us up to 10 business days to complete your request):

✈ Please mail records to:

Name: ______________________________________ Phone #: ____________________ Fax (optional):__________________

Address: ____ Town, State, Zip: _____________________________

✈ I will pick-up records when they are ready.

Name: ____ Phone #: _________________________

Photo ID is required when picking up records.

***FOR ALL PATIENTS 12 YEARS AND OLDER, THE PATIENT'S SIGNATURE IS REQUIRED*:**

____ Date: __________________

Signature of Patient (required for age 12 or over)

____ Date: ___________________

Signature of Parent/Legal Guardian (required for under age 18)

____ _________________________

Print Name of Parent/Legal Guardian Relationship to Patient

Expiration Date: This authorization will expire 1 year after the date signed or until the following event/date ___________.