Atlantic Pediatrics
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Transfer OUT

MEDICAL RECORDS TRANSFER AUTHORIZATION

Transfer Records to: *(New doctor, clinic or entity to receive the records)*

_____

_____

_____

For the following patient/child/or children:

_____ ____/____/____
Child1: Date of Birth

_____ ____/____/____
Child2: DOB:

_____ ____/____/____
Child3: DOB:

_____ ____/____/____
Child4: DOB:

_____
Your Address City State Zip

I hereby authorize the disclosure and/or transfer all medical records covering the period from birth to present, for the purpose of providing continuing medical care for my children or myself as listed above. This information to be disclosed will include:

☐Abstract of **last 2 years** of most pertinent information; progress notes, consult notes, shot records, labs, etc.

☐All information, inclusive of ☐Alcohol, ☐Drug abuse, ☐HIV testing, ☐Behavioral notes

☐Venereal disease, ☐ and/or other sensitive information:_____

Medical information is protected under law and, except as provided by law, cannot be disclosed without written consent. Information released with this authorization must not be given, sold, transferred, or in any way relayed to any other person or entity not specified above. When medical information is transferred, the sender cannot necessarily prevent further disclosure by the recipient under HIPAA privacy rules. This authorization may be withdrawn at any time by submitting a written revocation to the sender. This authorization will automatically expire 90 days from the date below.

Medical Records Charges Due from Parent or Patient: **$**_____

_____ _____
Printed Name of Parent/Guardian/Patient Relationship to Patient(s)

_____ _____/_____/_____
Signature Date

Comments: