Atlantic Pediatrics
Drs. Concannon & Vitale LLC
1145 Reservoir Avenue, Suite 124
Cranston, RI 02920-6055
Phone: (401) 943-7337 **Fax:** 401.942.1509 **Web:** AtlanticPediatricsRI.com

Transfer Records OUT

New provider & address

Request for Transfer of Medical Records to:

Please transfer my child's/children's medical records as listed below from Atlantic Pediatrics to:

Child Name: 1._____ Date of Birth: ____/_____/_____

Child Name: 2._____ Date of Birth: ____/_____/_____

Child Name: 3._____ Date of Birth: ____/_____/_____

_____ _____ , _____,_ _____
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, ☐Venereal disease (STD), ☐Behavioral notes, ☐ other

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 This authorization may be withdrawn at any time by submitting a written revocation to the sender.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.

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

_____ _____
Parent/Guardian/Patient Signature Best Phone #

Comments:

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