



## TRANSFER OF MEDICAL RECORDS RELEASE FORM

Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Additional siblings: \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

I, the undersigned, hereby authorize Pediatric Alliance, located at: \_\_\_\_\_

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To provide my medical record information to:

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone \* \_\_\_\_\_ Fax \* \_\_\_\_\_

- ☐ Date(s) of Service requested: \_\_\_\_\_
- ☐ I understand that the **entire** medical record, including information pertaining to drug or alcohol abuse and psychological or psychiatric treatment, will be provided unless I specify that the following information should **not** be released: \_\_\_\_\_

I am requesting the transfer of my child's/ children/s medical records due to:

- ☐ Relocation
- ☐ Child's age
- ☐ Dissatisfaction with physicians/ staff
- ☐ Insurance change
- ☐ Other: \_\_\_\_\_

Comments: \_\_\_\_\_

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I understand that I have a right to receive a copy of this authorization upon request.

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Or Parent/Legal Guardian: \_\_\_\_\_