PEDIATRIC MEDICINE, PA

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Request for Transfer of Medical Records

I, _____, authorize Pediatric Medicine, P.A. to release protected health information regarding:

Patient:_____
DOB:___/___/_____

Released information is to include:

___ Lab and Diagnostic Test Results
___ Immunization Record
___ Hospital Discharge Notes & Summary
___ Only portions of record from period: __/__/____to__/__/____
___ ALL Records

Please release information to:

Doctor/Clinic:_____
Address:_____
_____
_____
Tel:(___)_____
Fax:(___)_____

Signature:_____ Date: __/__/____
(Patient or Legal Representative)