

TRANSFER MEDICAL RECORDS FORM

Patient Name: _____ Date of Birth: _____

☐ Transferring Care to a New Medical Practice

Send Records to:

Name:
Address:
City, State, Zip
Phone Number:

I, _____ hereby request a copy of the Medical Record for the patient listed above.

➤ Relationship to Patient: ☐ SELF ☐ PARENT ☐ GUARDIAN ☐ OTHER: _____
Indicate legal relationship to patient

Disclose and Provide a copy of the following Records

Please Check All that Apply :

☐ Well Visits ☐ Office Visits ☐ Immunizations ☐ Medication List ☐ Lab/Radiology Results ☐ Drug/Alcohol Abuse

☐ Mental Health Treatment ☐ Genetic Testing ☐ HIV Test Results or Status

☐ Other _____

☐ Provide a copy of records from Date Range: _____ to _____ only.

- I understand I may inspect or obtain a copy of the protected health information described by this authorization.
- A nominal fee may be charged for the labor of copying, whether in paper or fax form, and supplies for creating a paper copy as permitted by law.
- This authorization becomes effective as dated and shall expire one (1) year from signature date
- I understand I have the right to withdraw my authorization at any time except to the extent that action has been taken in reliance on this authorization.
- I understand if I revoke this authorization, I must do so in writing and present my written revocation to the privacy officer of Dover Pediatrics.
- I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient, and if so, may not be subject to federal or state law protecting its confidentiality.
- I understand that Medical Records released pursuant to this authorization may include records generated by another healthcare provider or facility.
- Your record transfer, if applicable, will include all immunization registry information (NHIIS) sent to your new medical practice.

Requestor's Signature

Date