TRANSFER MEDICAL RECORDS FOR

Patient Name: ____ **Date of Birth:** ___________________

Indicate the Reason for this Requeset:

☐ **Transferring Care to a New Medical Practice**

☐ *Records Copy only -* *Patient is not transferring care*

☐ *I will pick up records (ID required)*

Name:	
Address:	
City, State, Zip	
Phone Number:	***Fax 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.**

____ ____________________

Requestor's Signature ***Date***