TOWN CENTER PEDIATRICS

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Authorization for Release of Medical Records

Please allow 2-3 weeks for processing requests

PATIENT INFORMATION

Patient's Name: _____Date of Birth: _____
Patients Address: _____
City: _____State:_____ Zip: _____Phone #:_____

RELEASE INFORMATION

Town Center Pediatrics is authorized to release medical records for the person named above to:
Name/Facility: _____
Address: _____
City, State, Zip: _____

Reason for release ☐ Insurance ☐ Transferring to a different practice
☐ Transfer due to age ☐ Moving

You must check one

_____ $30 "Abstract" medical record

_____ $50 Complete medical record

"Abstract" contains all immunizations, past 2 years of office visits and labs, and 5 years of radiology, diagnostic reports and consultations.

This is sufficient to meet the needs when transferring to a new provider.

Records will be released once payment has been received

RELEASE OF SENSITIVE INFORMATION

☐ Yes ☐ No ***you must check one for <u>any</u> type of medical record request***

I understand that the medical record may include information about sexually transmitted diseases, AIDS/HIV testing and results, domestic violence, sexual abuse, abortion, genetic testing, mental health services or treatment for alcohol and drug abuse, and I agree to its disclosure.

I understand that I have the right to revoke this authorization at any time, and I must do so by submitting a written request to Town Center Pediatrics medical records department. I understand that the revocation will not apply to information that has already been released based on this authorization. I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal confidentially rules.

_____ _____
Signature of parent/legal guardian **OR patient if 18 years or older** Date

_____ _____
Print name of above signature Relationship to patient