Authorization to Release Medical Records

Name of Practice records are coming from:	Name of Prior Doctor:
Address:	
Phone:	Fax:

I have transferred my child(ren)'s medical care to the practice listed below and hereby request that my child(ren)'s protected health information in your possession(the entire record) be sent in paper or cd format to:

ABC Pediatrics
740 S. New Street
Dover, DE 19904
Phone 302-674-0222

Patient Name	D.O.B.

Effective Date:_____ If different form is necessary please contact(___)_____

I understand that the information to be released may include the following conditions if present: drug or alcohol abuse, psychological or psychiatric conditions, HIV or AIDS testing or diagnosis. This is a one time authorization that will expire in 180 days. I understand that I may revoke this authorization in writing. If I revoke this authorization is it not effective to the extent that the practice has already relied on the use or disclosure of the protected health information. I further understand that I do not have to sign this authorization in order to obtain health care benefits (including treatment, payment, or enrollment).

A copy of this authorization may be utilized with the same effectiveness as the original.

Authorized Signature:_____	Date:
Printed Name:_____	Relationship to patient: