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Pediatrics Southwest

RECORDS TRANSFER REQUEST FROM PEDSW

Date: _____

I authorize the release/transfer of my child's/children's pertinent medical records to:

Facility/Dr.: _____

Address: _____

City, State, Zip Code: _____

Phone/Fax No: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

The purpose for this request:

- ☐ Family Move
- ☐ Switching Doctors
- ☐ Insurance Change
- ☐ Other _____

This authorization will automatically expire in six (6) months from the date of my request.

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. I have the right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

Signature of parent Date _____

_____

Printed name of parent

_____