Mark D. Towns, M.D. • Louis A. Hunke, M.D. • Thomas W. Deacon, M.D.
Jacquelynn A. Longshaw, M.D. • Elizabeth R. Keyes, M.D.

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