AUTHORIZATION FOR TRANSFER OF MEDICAL RECORDS

Patient Name: ____**DOB:** __________________

Address: ____**Tel #:** _____________________

City, State, Zip: ____

RELEASE RECORDS TO:

Physician/Facility/Self: ____

Address: ____

City, State, Zip: ____

Please release the following information (check one):

_____ All records, including those pertaining to substance abuse, HIV/AIDS, if applicable

_____ All records, not including those pertaining to substance abuse, HIV/AIDS, if applicable

RECORDS FORMAT: PAPER RECORDS MAILED

Note: If the patient is a minor, the guardian must sign. If the patient is an adult (18+) and does not sign this consent form, the party signing must provide legal documentation providing their authority to do so. This information will not be given, sold, transferred, nor delayed to any individual not specified on this authorization without first obtaining written consent that shall state the need for the use of this information or the need for its purpose of being transferred.

I understand that I will be liable for the transfer fee of $20.00 per child and any outstanding balance(s) on the account if records are being released to myself.

If records are being mailed directly to the new Physician, the transfer fee is waived, however, the patient/parent will still be responsible for any outstanding balance(s).

****Transfer request requires 7-15 business days to process****

Print Name (if not patient): ____ **Relationship:** ____________________

Signature: ____ **Date:** _________________________

(Patient or Legal Representative)

Reason for Transfer: **___Relocation | ___Age | ___Change of Insurance | ___Personal | ___Other**