HEIGHTS PEDIATRICS

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Transfer Medical Record Release Authorization Form

This form is used to release records to the following doctor or hospital

Name of Patient: _____

Date of Birth: _____ Phone: _____

Patient's Address: _____

Purpose for Release : _____

Authorization Expiration Date: ____ / ____ / _____

I would like Heights Pediatrics to send records to (check one):

☐ Doctor ☐ Myself

Doctor or Hospital Name: _____

Address: _____

Phone: _____ Fax: _____

For Dates of Service: From: ____ / ____ / _____ To: ____ / ____ / _____

I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. I understand that once my medical records are disclosed, they may no longer be protected by federal privacy regulations. I understand and acknowledge that the release of medical records is voluntary and that the treatment, payment, or eligibility for benefits and services may be conditioned upon obtaining my/our authorization to release these records. I further understand that the information disclosed may include sensitive medical and/or mental health information. I understand that each copy of printed/mailed records begins at $20 and incurs a fee of 75 cents per page exceeding 40 pages. I understand electronic copies via fax or USB are a base price of $20. Lastly, I understand mailed records are subject to an additional delivery fee, determined by Fedex, which will be charged via card on file.

I would like my records via ☐ Fax ☐ USB ☐ Printed ☐ Mailed via Fedex

Parent/Guardian Full Name (Print): _____

Parent/Guardian Signature:_____ Date: ____ / ____ / _____

This authorization form has been reviewed, and the release of medical records has been authorized in accordance with applicable HIPAA regulations.

Staff Witness: _____