MEDICAL RECORD TRANSFER FORM

____ DOB: __________________________

Patient Name

____ SS#: __________________________

Patient Address

I authorize ____

Name of Physician, Practice, Facility, etc.

to transfer personal health care information for myself/my child to:

Pediatric Care of Rockville, 6000 Executive Boulevard, Suite 310, Rockville, MD 20852, 301-881-7995.

The information to be released is (state specific documents, time period, etc.):

Purpose or need for the information requested:

Continued Care ______ Insurance ______ Legal _______ Transfer ______ Personal ______

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated and signed communication. This consent will remain in effect no more than ninety (90) days from the date I signed this consent. I also understand that my medical records may include mental health information, drug/
alcohol information and/or HIV information.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

_________________________________ _________________________ _________________________

Patient/Parent/Legal Guardian Signature Relationship Date

_________________________________ _________________________

Witness Signature Date

If signed by other than patient, state relationship and reason for patient's inability to sign.

A copy of this authorization has been _________ accepted _________ rejected by the patient or representative. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified.

Office Use Only: