Healthy Starts Pediatrics

Medical Records Transfer Form

Authorization to release or receive medical records for:

PATIENT NAME

DATE OF BIRTH

STREET ADDRESS

CITY

ZIP CODE

PHONE NUMBER

I Authorize Healthy Starts Pediatrics to:

◯ RELEASE MEDICAL RECORDS TO ◯ RECIEVE MEDICAL RECORDS FROM

Practice/Individual

Fax Number

Address

Information I am requesting

All pertinent records for the past 2 years, INCLUDING HIV test results, mental health, drug and alcohol, and psychiatric and psychotherapy treatment

If you wish to EXCLUDE HIV test results, mental health, drug and alcohol, and psychiatric and psychotherapy treatment, please initial here:

Patient Name:

Date of Birth:

Reason for requesting records:

- ☐ Transfer to adult/family practice
- ☐ Transfer due to change of insurance
- ☐ Transfer, moved out of area
- ☐ Specialist Visit
- ☐ Other, please specify to the right

Signature of parent/guardian **if patient is under 18**

Date

Printed name of parent or guardian of minor

Relationship to patient

Signature of patient if **18 years of age or older**

Date

Printed name of patient age 18 or older