



Receiving records From

Previous Practice or Provider Name: _____

Address: _____ Phone: _____ Fax: _____

Sending Records to:

Practice or Provider Name: _____

Address; _____ Phone: _____ Fax: _____

Patient Information:

Name: _____ DOB: _____

Address: _____ Phone #: _____

What would you like? Check all that apply.

All Records Office/Clinic Notes Lab Immunization Records Other

Purpose of Disclosure: _____

Delivery Method: Fax Mail _____ Email

I hereby authorize Pediatric Diagnostic Associates to release or disclose to the person(s) or organization listed above all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell, anemia, HIV infection, unless otherwise noted. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to redisclosure by the recipient listed above and will no longer be protected by federal regulations. I understand that I can refuse to sign this authorization, and my healthcare provider may not condition treatment on my signing this authorization.

Signature of Patient or Parent/Legal Guardian/Personal representative: _____

Relationship to Patient: _____ Today's Date: _____