Harvest Pediatrics

Comprehensive Health Care for Infants, Children & Adolescents

AUTHORIZATION FOR TRANSFER OF MEDICAL RECORDS/CARE

Patient's Name: _____ Date of Birth: _____

Parents/Guardian: _____ Telephone No: _____

Address: _____

_____

Are you leaving the practice? _____

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: Information and record regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.

AUTHORIZATION: I hereby authorize _____ to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and /or medical records by means of mail, fax or other electronic methods to:

_____
Name

_____
Address

_____
Ciity, State and Zip Code

The medical information/records will be used for the following purpose: _____
This authorization is:

- ☐ Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment.)
- ☐ Limited to the following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse_____ (initial) Tests for Antibodies to HIV _____ (initial)

Psychiatric/Mental Health _____ (initial) HIV Diagnosis/Treatment _____ (initial)

DURATION: This authorization shall be effective for one (1) year unless otherwise noted.

RESTRICTIONS: Permissions for further use of disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

All records released by Harvest Pediatrics will be subject to a fee of $25.00 per chart, due before records are released, as allowed by California and Federal law. Fees may increase to be determined by chart size and/or amount of pages copied. Only records of care done at Harvest Pediatrics or by a physician at Harvest Pediatrics will be released.

Signature: _____ Relationship to patient: _____

Date: _____ Patient Account No.: _____

Witness: _____