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Medical Release of Information Form Transferring Out

THIS AUTHORIZATION WILL EXPIRE TWELVE (12) MONTHS FROM THE DATE SIGNED.

Patient Name: _____ Date of Birth: _____

I request and authorize Cornerstone Pediatrics and Adolescent Medicine to release the medical record of the above-named patient to:

Name of Recipient: _____

Address/City/State/Zip _____

Phone Number_____ Fax Number_____

Reason for Release: _____

This request and authorization applies to: Please *initial next to the appropriate line. (Please initial only one)*

_____ ALL HEALTHCARE INFORMATION **including** immunization records, well and sick visits, labs, x-ray reports.
NOTE: There is a **fee of $25.00** for the first child and a **fee of $10.00** for each additional child.
If patient is aging out of the practice or under the age of 1, no charge applied

_____ MOST RECENT HEALTHCARE INFORMATION **including** immunization records, last physical exam with labs.
NOTE: There is a **fee of $5.00** for each child.

*****REQUESTS WILL NOT BE PROCESSED UNTIL PAYMENT IS MADE*****
****PLEASE SUBMIT PAYMENT WITH REQUEST****
PLEASE ALLOW TEN (10) TO FOURTEEN (14) BUSINESS DAYS TO PROCESS YOUR REQUEST.

Please initial the following acknowledgement:

_____ I understand I have the right to revoke this authorization by providing a written request to do so to the above-named physician or organization. I understand that the revocation will not apply to information that has already been released.

_____
[*Signature of patient or authorized representative*] [*Date*] [*Relationship to patient]*

_____ _____
[*Parent / Patient Phone Number*] [Parent / Patient *Email Address]*