SouthPark Pediatrics, PA

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Consent for Release of Medical Records

From: Patient's Name _____

Patient's Address _____

Patient's DOB/Social Security Number _____

I do hereby consent and authorize you to release copies of the above named patient's medical records, including, as determined necessary by the physicians, current and previous medical records from other practices and practitioners, hospitals and/or clinics that are a part of the medical record.
PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information; and any information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and any AIDS-related syndromes. It also includes any information concerning cancer, cancer testing, and cancer results. I agree that a copy of this release or a fax of this release shall be as valid as this original release. Please send copies of all requested information as soon as possible to the address listed below:

_____ SEND IMMUNIZATION RECORD

_____ SEND MEDICAL RECORD SUMMARY (It is our policy to provide only records of our care, not those of previous physicians or specialists.)

REASON FOR TRANSFER

___ INSURANCE ___FAMILY RELOCATION ___PROXIMITY TO HOME

___ OTHER_____
(Please explain)

___Please terminate my patient-physician relationship with SouthPark Pediatrics, PA.

MAIL/FAX RECORDS TO:

Practice_____ MD_____ Appointment Date_____

Address:_____

City/State/Zip Code:_____Phone #:_____Fax #:_____

*****Patient, Parent, or Legal Guardian _____
Signature Date