

**SouthPark Pediatrics, PA**  
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Phone 704-522-6656 Fax 704-522-6665

**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

**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:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*Patient, Parent, or Legal Guardian** \_\_\_\_\_

Signature

Date