MEDICAL RECORDS RELEASE FORM

Patient Last Name | First Name | MI | Date of Birth

Street Address | City | State | Zip Code

I authorize Kids Plus Pediatrics to provide medical records for the patient named above to:

Name | Date

Address | City | State | Zip Code

Reason for Transfer: _____ Insurance change _____ Transfer of Care _____ Legal
_____ Moving out of area _____ Specialty Consultation _____ Personal

Records I Would Like Released:

☐ All Records From the Last Two Years (including Well Visits, Sick Visits, and Phone Messages)
☐ Immunization Records & Growth Chart
☐ Specialist Notes From the Last Two Years
☐ Other (Please Specify): _____

I understand the Kids Plus treatment record, including information pertaining to drug or alcohol abuse and psychological or psychiatric treatment, will be provided unless I specify the following should NOT be released.

Specific Information NOT to be Released

Signature

Release or transfer of the specified information to any person or entity not specified here is prohibited. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to Kids Plus Pediatrics. I understand the revocation will not apply to information that has already been released in response to this authorization. I also understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that once this health care information is released, redisclosure of it by the recipient may no longer be protected by law.

This authorization is valid for one year from the date on this form or until _____ (specify date.)
I understand I have a right to receive a copy of this request.

Patient/Parent/Legal Guardian Signature:_____ Date:_____

RECORDS WILL BE MAILED WITHIN 30 DAYS OF RECEIPT OF COMPLETED RELEASE FORM.
(60 DAYS IF RECORDS ARE OFF-SITE.) THERE MAY BE FEES ASSOCIATED WITH THIS REQUEST.