



Records Request

Use this form if you are requesting that another provider or practice release your information to Rose Pediatrics. Please note that you are responsible for following up with THAT provider to ensure the records have been sent.

Patient information

Patient Name	Last:	First:	Middle initial:
Patient DOB			
Parent/Guardian Name			
Patient Address			
	City:	State:	Zip:
Parent/Guardian Phone Numbers	(home)	(work)	(cell)

Records to be released FROM

Practice/Provider Name			
Address			
	City:	State:	Zip:
Phone Number			Fax Number:

Reason for Release (please check one)

Information to be released (please check one)

<input type="checkbox"/>	Changing Offices	<input type="checkbox"/>	Entire chart
<input type="checkbox"/>	Change of Insurance	<input type="checkbox"/>	Labs/X-rays only
<input type="checkbox"/>	Moving out of State	<input type="checkbox"/>	Consult notes only
<input type="checkbox"/>	Other (please explain):	<input type="checkbox"/>	Other (please explain):

I request and authorize you to release the information specified to the organization, agency, or individual named on this request. I understand that the information to be released may include information regarding all conditions including HIV/Aids, Drug Abuse, Alcoholism or Alcohol abuse, or Psychological or Psychiatric conditions (unless crossed out). I certify that this request has been given voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Re-Disclosure of my medical records by those receiving the above authorization information may not be accomplished. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event 180 days from the date hereof. A copy of this authorization or signature thereon may be utilized with the same effectiveness as an original.

Signature of Parent/Guardian	
Relationship to Patient	
Date Signed	

Rose Pediatrics Use

Date Received & Initials:	Date Records Transferred and Initials:
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Please note that a separate request form must be completed for each child in your family.