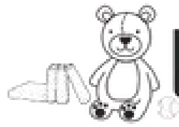

TRANSFER OF MEDICAL RECORDS RELEASE FORM

Patient Last Name:____________________________ First Name:_____________________ DOB:__________

Additional siblings:____

____

Address:____Phone:____________________

I, the undersigned, hereby authorize Lindenhurst Pediatrics, located at: 2031 E Grand Ave. Ste 200 Lindenhurst, IL 60046

To provide my medical record information to:
Practice Name:____

Address:____
Phone: ______________________________ Fax: ______________________

- Date(s) of Service requested: ________________________________
- I understand that the **entire** medical record, including information pertaining to drug or alcohol abuse and psychological or psychiatric treatment, will be provided unless I specify that the following information should **not** be released:___________________________________

I am requesting the transfer of my child's/ children/s medical records due to:

__ Relocation
__ Child's age
__ Dissatisfaction with physicians/ staff
__ Insurance change
__ Other: ____

Comments: ____

I understand that I have a right to receive a copy of this authorization upon request.

Date:___________________________

Patient Signature:____

Or Parent/Legal Guardian: _____________________________________