LIVE WELL PEDIATRICS

AUTHORIZATION FOR TRANSFER OF MEDICAL RECORDS

Please be aware the record release processing fee **must** be paid before records can be sent.

I, _____, do hereby authorize _____ to release all medical records pertaining to the patient(s) listed below:

Patient's Name: ..... DOB: .....

Patient's Name: ..... DOB: .....

Patient's Name: ..... DOB: .....

Patient's Name: ..... DOB: .....

Patient's Name: ..... DOB: .....

Patient's Name: ..... DOB: .....

Send Records to: _____

_____

_____

☐ ENTIRE CHART
☐ LAST WELL VISIT, GROWTH CHARTS AND IMMUNIZATIONS ONLY

I hereby authorize disclosure of the health information for the above names patient(s). This authorization is valid for 12 months from the date of signature. I understand that they legally have 30 days to release my records. I also understand that I may cancel this request with written notification but that it will not affect any information release prior to notification of cancellation.

_____
Signature of Patient (Signature of parent/legal guardian if patient is a minor)

_____
(Phone number to call when records are ready)