Authorization for Release of Medical Information – Transferring Out

Patient Name: ____
DOB: ____/____/_______

I, ______________________________________ hereby authorize the release of medical information **FROM:**

Puddle Dock Pediatrics
200 Griffin Road, Suite 12A
Portsmouth, NH 03801
603.457.7040 (office) 603.550.5244 (fax)

TO:
Doctor/Clinic/Hospital:____

Address: ____

____

Telephone: ______________________________ Fax : ________________________

Please release the following:
___ **All health information (including growth charts and vaccination records)**
___ History/Physical Exam
___ Progress Notes
___ Discharge Summary
___ Consultation Reports
___ Other (specify): __________________________________
___ Diagnostic Test Reports
___ Radiology/Images
___ Lab Results
___ Pathology Reports

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records

___ Yes, I consent to the release of this information.
___ No, I do not consent to the release of this information.

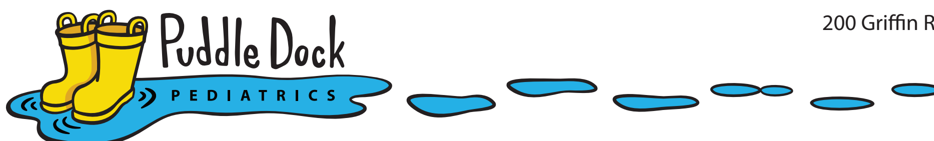
Purpose of disclosure:
___ Treatment/ Continuing medical care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature of Parent or Legal Guardian: __________________________________ Date: ____/____/____

Best Contact # for Parent or Legal Guardian: ____

Print Name: __________________________________ Relationship to Patient: ___________________



200 Griffin Road, Suite 12A, Portsmouth, NH 03801
www.puddledockpediatrics.com
p. (603) 457-7040
f. (603) 550-5244