



HENDERSONVILLE
PEDIATRICS, P.A.

HENDERSONVILLE PEDIATRICS, P.A.
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION INCOMING RECORDS

Please fill out the following and return to the office using the correct address from above.

I hereby request that _____ (*name of practice*) copy and release the copies of medical records as specified below for my child/children or myself to Hendersonville Pediatrics.

NAME OF PATIENT	DATE OF BIRTH	NAME OF PATIENT	DATE OF BIRTH

_____ I request immunization records only be sent to Hendersonville Pediatrics.

_____ I request and authorize _____ (*name of practice*) to release all medical information and records concerning the history, treatment, examination, hospitalizations, and any other information that may be related to drug, alcohol, psychiatric conditions, an/or sexually transmitted disease, including HIV/AIDS information from _____ (*date*) to: please fill in information below. Such records will be disclosed unless specified information to exclude is listed below.

Exclusions: _____

Your current Information	Information for Where Records Should Be Released From:
Name:	Name of Practice:
Street Address:	Street Address:
City, State, Zip:	City, State, Zip:
Phone Number:	Phone Number:

Reason for the record transfer: (*please mark and fill in requested information.*)

_____ Moving out of state: (*please provide new information and the date they become effective in case we need to contact you.*)

My new address and phone number take effect on _____ Phone _____

Address _____

City _____ State _____ Zip _____

_____ Changing to another practice due to (*please box for reason*):

- Insurance change
 Location
 Age of Patient
 Size of Practice
 Other (*please specify*) _____

• I understand that the release or transfer of the information specified above to any person or entity not specified above is prohibited.

• I understand that I may revoke this consent at any time except to the extent that action has already been taken and that it expires 90 days from the date indicated below.

• I understand that it take approximately 10 working days to complete this request.

Signature _____ Date _____

Relationship to Patient _____ (*Patient must sign if 18 years of age or older.*)