REQUEST FOR MEDICAL RECORDS

I, ______________________________(parent/guardian) authorize the following physician to release my child/children's medical records, which should include all drug/alcohol abuse, psychiatric and records containing HIV test results.

TRANSFERRING FROM:

Physician's Name:____

Complete Address:____

Phone #/Fax #:____

TRANSFERRING TO:

Physician's Name:____

Complete Address:____

Phone #/Fax #:____

CHILD/CHILDREN INFORMATION:

Name(s):____

Date(s) of Birth:____

Street Address:____

Phone #/Fax #:____

REASON FOR RECORD RELEASE (Please check one):

_______ Transferring to a NEW Physician

_______ Seeing a specialist for continuing care – NOT transferring

_______ Immunizations and/or physical ONLY – NOT transferring

_______ Other (Please explain)____

____ ___________________

Signature of patient responsible for patient Date of Request/Transfer