

Forest Hills Pediatric Associates, PC

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Please Transfer my child's medical record from Forest Hills Pediatric Associates, PC to the following physician:

Please send a copy of my child's medical record from Forest Hills Pediatric Associates, PC to the following consultant:

Release to: _____

Name

Address

City

State

Zip

Medical Information To Be Sent:

Entire Medical Record, *INCLUDING* information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment: information related to testing or treatment of HIV/AIDS.

Entire Medical Record, *EXCLUDING* information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment: information related to testing or treatment of HIV/AIDS.

Record of care from _____ to _____ *INCLUDING* information related to treatment for substance abuse or dependency; psychiatric or mental health treatment: information related to testing or treatment of HIV/AIDS.

Record of care from _____ to _____ *EXCLUDING* information related to treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of HIV/AIDS.

If deemed necessary by Doctor _____, I authorize this information to be sent via fax transmission.

Other _____

I authorize medical information to be released as indicated above. I understand this release is effective for 6 months from the date of execution, but that I may revoke my consent at any time by providing written consent to the above named party.

Patient or Patient's Legal Guardian

Relationship to Patient

Phone Number

Date

Witness

Date