Ellenton Pediatrics

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RECORDS OUT AUTHORIZATION
(Transfer of Patient Records To A New Physician)
Fee for Medical Records Copying / One Week Turn Around Time Requested

Date _____

Child's Name _____ Date of Birth _____

Child's Name _____ Date of Birth _____

Child's Name _____ Date of Birth _____

As the parent or legal guardian, I authorize Ellenton Pediatrics to furnish a copy of my child's/children's records of medical care and treatment to:

New Physician _____ Clinic Name _____

New Physician's Phone _____ New Physician's Fax _____

Physician's Address _____

Please initial for requested records:

___ Immunizations ___ Consultations ___ Physical Exams ___ Lab, X-ray Results

Reason:

☐ Moving Out of Area ☐ Change of Insurance ☐ Other, be specific _____

Parent's Name _____ Telephone _____

Parent's Address _____

Parent's Signature _____

Witness _____ Witness's Signature _____