



## RECORDS OUT AUTHORIZATION (Transfer of Patient Records To A New Physician) \$15 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 \_\_\_\_\_