PRIMARY PEDIATRICS
59 CAVALIER BLVD, SUITE 330
FLORENCE, KY 41042
PHONE (859) 371-3232

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

□**Transfer to Primary Pediatrics** □**Transfer from Primary Pediatrics**

I, the undersigned, hereby authorize _____ to release

my child's/children's medical record to _____.

This authorization includes, if applicable, release of information concerning HIV testing or treatment of AIDS, AIDS related conditions, drug or alcohol abuse, drug-related conditions, alcoholism and/or psychiatric/psychological conditions. This authorization includes, but is not limited to all records of office visits, examinations, evaluations, diagnostic and laboratory testing, reports, consultations, hospital records, psychological counseling notes, correspondence for treatment or services rendered to my child(ren) by _____.

**Patient Information (Please Print)**

Child's Name:_____ DOB:_____

Child's Name:_____ DOB:_____

Child's Name:_____ DOB:_____

Child's Name:_____ DOB:_____

**If you are transferring from Primary Pediatrics to another medical office, please tell us the reason by marking the appropriate box and give us address and phone number where to send records.**

□ Change in insurance □ Patient move □ Dissatisfaction with physician/office staff

□ Other please specify: _____

**Please forward records to:**

_____

_____

_____

_____

_____

**Signature of Legal Guardian** **Relationship** **Date**
**Or**
**Signature of Patient if 18 or older**