



MEDICAL RECORD TRANSFER FORM

Patient Name

DOB: _____

Patient Address

SS#: _____

I authorize _____
Name of Physician, Practice, Facility, etc.

to transfer personal health care information for myself/my child to:
Pediatric Care of Rockville, 1201 Seven Locks Road, Suite 201, Rockville, MD 20854, 301-881-7995 (P), 301-881-8451 (F).
The information to be released is (state specific documents, time period, etc.):

Purpose or need for the information requested:

Continued Care _____ Insurance _____ Legal _____ Transfer _____ Personal _____

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated and signed communication. This consent will remain in effect no more than ninety (90) days from the date I signed this consent. I also understand that my medical records may include mental health information, drug/ alcohol information and/or HIV information.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

Patient/Parent/Legal Guardian Signature

Relationship

Date

Witness Signature

Date

If signed by other than patient, state relationship and reason for patient's inability to sign.

A copy of this authorization has been _____ accepted _____ rejected by the patient or representative. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified.

Office Use Only: