

**RELEASE OF RECORDS**

**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_/\_\_\_/\_\_\_

I authorize PANORAMA PEDIATRIC GROUP, RLLP to: (check one)

\_\_\_\_\_ **Send** medical records to:                    **OR**                    \_\_\_\_\_ **Obtain** medical records from:

**Name:** \_\_\_\_\_ **Phone:** (\_\_\_\_)-\_\_\_\_-\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

The Protected Health Information (PHI) to be released consists of:

\_\_\_\_\_ All Records **OR** \_\_\_\_\_ All Records excluding: \_\_\_\_\_ Alcohol/Drug related information

\_\_\_\_\_ Mental Health related information

\_\_\_\_\_ Selected Item(s): \_\_\_\_\_

**By law:** All HIV/AIDS related information requires a separate authorization form.

Records within the chart from other medical providers will not be transferred.

If transferring care, please indicate the reason:

\_\_\_\_\_ Easier Access/Closer    \_\_\_\_\_ Insurance Issue    \_\_\_\_\_ Over Age 18    \_\_\_\_\_ Dissatisfaction

\_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_ Moving: New address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_

**Comments:** \_\_\_\_\_

**(Optional)**

**Note:** We will retain your original records until you reach the age of 24 or until it is been 6 years since your last visit. Please allow at least one month for a copy of your records to be transferred. We do not fax protected health information. **If records have been transferred once, there will be a retrieval and a \$.75/page charge for medical information needed a second time for any reason.**

*This authorization shall remain valid until terminated in writing or upon transferring care from PPG.*

\_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_  
**Signature of:** [ ] Patient, if over 16, [ ] Parent, [ ] Guardian, [ ] Authorized Representative

Printed Name of Above: \_\_\_\_\_ Current Phone #: (\_\_\_\_)-\_\_\_\_-\_\_\_\_

Current Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

---