



Medical Record Release

Patient information

Patient name: _____
Date of birth: _____
Phone: _____
Address: _____ Apt #: _____
City: _____ State: _____
Zip: _____

Release information to

Name/Facility: _____
Address: _____
City: _____ State: _____
Zip: _____

Specific information to be disclosed and released

Medical record from this date: _____
to this date: _____
 Entire medical record, including patient histories, office notes
(except psychotherapy notes), test results, radiology studies, films,
referrals, consults.
Comments: _____

Specific information to be withheld

To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. I have indicated below that I do or do not permit information of this type, if it exists, to be released. I understand that if I do not indicate a choice, Westwood-Mansfield Pediatric Associates will release such information about me if it exists.

HIV/AIDS infection Yes No
Genetic information Yes No
Mental health Yes No
Sexually transmitted diseases Yes No
Treatment for alcohol and/or drug abuse Yes No

Specific information to understand

- I understand that my records are protected under the federal privacy laws and regulations and under state law, and cannot be disclosed without my written consent except as otherwise specifically provided by law.
- It is my understanding that this authorization will expire in one (1) year from the date signed below. I understand that I may revoke this authorization by notifying Westwood-Mansfield Pediatric Associates. I understand that any previously disclosed information would not be subject to my revocation request.

Reason for release

In an effort to better serve our patients, it is important for us to understand the reason that your child/young adult is leaving our practice. Please select the reason below and provide a description as well. You may utilize the back of this form if more space is needed.

- Transfer to an adult provider
- Moving away to:
City: _____ State: _____
- Insurance change
 - Providers not in new network
Network name: _____
 - Tiering/higher co-pay/higher deductible cost
- Long wait times
- Management of my child's health care
Please elaborate: _____
- Unsatisfactory staff interaction
Please elaborate: _____
- Other: _____

This form must be fully complete before signing

Signature of patient or patient's legal representative:

Print patient's name:

Print legal representative's name (if applicable):

Relationship to patient: _____
Date: _____