Lovenheim Pediatrics

Infants - Children - Adolescents

RECORD RELEASE AUTHORIZATION:

DATE:__________________

I, ____HEREBY AUTHORIZE THE RELEASE OF MY CHILD(CHILDREN'S) MEDICAL RECORDS IN ORDER TO TRANSFER TO ANOTHER PHYSICIAN:

CHILD(CHILDREN'S) NAME:____

____

DOB:____

RELEASE TO:

1.) SELF:(name:)____

ADDRESS:____

2.) PHYSICIAN NAME:____

ADDRESS:____

PHONE:________________________________FAX#:__________________________

I UNDERSTAND THAT BY SIGNING THIS FORM I AM INFORMING LOVENHEIM PEDIATRICS OF MY INTENTION TO TRANSFER TO ANOTHER PRACTICE AND THAT I HAVE THIRTY (30) DAYS FROM THE DATE OF THIS FORM TO BE SEEN FOR EMERGENCY VISITS. I UNDERSTAND THAT LOVENHEIM PEDIATRICS HAS UP TO 30 DAYS TO COMPLETE THIS REQUEST.

SIGNATURE:____
(IF RELATIVE, STATE RELATIONSHIP:)