Incoming Transfer Request Form

By signing this document, I authorize:

____
Name of Previous Physician

____
Address

____

To disclose protected health information about my child/children to:

Pediatric Associates, PA
4735 Ogletown Stanton Road
M.A.P. 2 Suite 1116
Newark, Delaware 19713
302-368-8612

To Be Released:

Exact Information Must Be Specified

( ) Summary of Care
( ) Operative Reports
( ) All Records
( ) Discharge Summary
( ) Laboratory Reports
( ) Radiology Reports
( ) Previous Physician Records
( ) History and Physical
( ) Progress Notes
( ) Diagnostic Reports
( ) Drug/Alcohol Reports
( ) Immunizations

( ) Other:____

Authorization:

____
Patient Name | Date of Birth

____
Chart Name (If different from patient) | Relationship to Patient

____
Signature of Authorized Person | Date