Patient Transfer Request Form

By signing this document, I authorize Pediatric Associates, P.A. to transfer my protected health information to the party listed below.

Release To:

Name

Address

To Be Released:

(X) All Records

Reason For Transfer:

(X) Age

When my information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may not longer be protected by the federal HIPAA Privacy Rule. This form has been fully explained and I certify that I understand its content.

Authorization:

Patient Name Date of Birth

Signature Date