Request for Outside Providers Release of Medical Records

I hereby request the release of protected health information:

Patient Name: _____

Date of Birth: _____ Telephone Number: _____

Address: _____

INFORMATION BEING REQUESTED:

Providers Name: _____

Address: _____

Phone: _____ Fax: _____

RELEASE INFORMATION TO:

Island Pediatrics, LLC
5030 Anchor Way, Ste. 6
Christiansted, VI 00820
Phone: 340-202-1997 Fax: 949-561-5692
Email: jamied@islandpediatricsvi.com

REASON FOR RELEASE OF INFORMATION:

[ ] Transfer or copy of medical record to new provider; or
[ ] Other.

DESCRIPTION OF INFORMATION TO BE RELEASED:

[ ] Entire medical record;
[ ] Medical Records from Date: _____ to _____;
[ ] Lab Records from Date: _____ to _____;
[ ] Specific Report.

I understand that the information described above may be redisclosed by the person or group that I am giving the Agency permission to disclose and therefore my information may no longer be protected by Federal privacy regulations. I understand that I may inspect, or request copies of any information disclosed by this authorization if the Agency initiated this request for disclosure. I understand that I may revoke this authorization by notifying the Agency in writing with the understanding that previously disclosed information would not be subject to my revocation request.

Signature of Patient or Authorized Legal Representative:

_____ Date: _____

Print Name/Authorized Person: _____

Relationship to Patient: [ ] Self, [ ] Parent, [ ] Legal Guardian, [ ] Power of Attorney