Walden Pond PEDIATRICS

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RECORDS RELEASE

Patient Name _____ DOB _____

REASON FOR DISCLOSURE
( ) Transferring care to another provider (Effective date of Transfer _____)
( ) Other: Please specify Reason _____

INFORMATION TO BE DISCLOSED
( ) Entire medical record (please note, we do not release records to 3rd parties, but only to patients or parents/guardians)
( ) Record covering the following dates only: From _____ To _____
( ) Other: Please specify Details _____

INFORMATION TO BE DISCLOSED TO
NAME _____

ADDRESS _____

DISCLOSURE OF SENSITIVE INFORMATION
Certain types of sensitive information require specific authorization to be released. Please indicate below if you would like the following types of information to be included in the release. A check indicates that you DO want to include the information. Not checking the statement indicates you DO NOT want to include the information.

( ) HIV/AIDS Testing or Treatment
( ) Pregnancy/Sexual Health
( ) Substance Use/Abuse
( ) Social Work Notes
( ) Mental/Behavioral Health Info

RE-RELEASE OF INFORMATION
( ) I authorize Walden Pond Pediatrics, PC to re-release records from other physicians or facilities that may be included in the medical record (i.e.: letters from consultants)

Patient Name (print):_____

Signature: _____ Date: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ Relationship to Patient: _____