GROW PEDIATRICS

Authorization to Release Medical Records

By filling out this form, I, _____, being the patient, parent, or legal guardian of the patient, do hereby request Grow Pediatrics. to release medical records as specified by the form below.

CLINIC OR PHYSICIAN TO RELEASE RECORDS TO:		
Clinic Name or Physician Name:		
Address:	Fax or Email:	
City:	State:	Zip Code:

MEDICAL RECORDS TO BE TRANSFERRED:
Type of Release: _____ All records relating to _____ (please specify) _____ Entire Patient Record
Reason for Release: ___ Change of Insurance ___ Consult/Second Opinion ___ Moving Out of Town ___ Change of Physician (unhappy with care at Grow Peds) ___ Change of Physician (happy with care at Grow Peds)
If you answered that you were unhappy with your care at Grow Pediatrics, can we contact you for additional feedback? ____ Yes ____ No

Patient Name:	Date of Birth:
Patient Name:	Date of Birth:
Patient Name:	Date of Birth:
Patient Name:	Date of Birth:

This authorization is valid for up to one (1) year after my signature appears on this form and authorizes the release of the patient records up to and including the date of this release. I may revoke this authorization at any time except to the extent that the records have already been released. Any re-disclosure of this information, depending on the nature of the information, may not be permitted without my specific authorization.

Patient, Parent, or Legal Guardian Signature:	Date:
Address:	Phone: