# MEDICAL RECORDS TRANSFER FORM

If you would like your medical records transferred between Quad Cities Pediatrics, P.C. and another physician, please complete this form and submit it to Q. C. Pediatrics, P.C. Please complete **one form for each physician office** from/to which you would like your records transferred.

## PATIENT AUTHORIZATION

Last Name:_____ First Name:_____ MI:____ DOB:_____ Male__ Female__

Home Address:_____

**FROM/TO *(Please circle intended direction)***

Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

**FROM/TO *(Please circle intended direction)***

Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

**PURPOSE OF DISCLOSURE**

__Continuing Care __Insurance __Legal __Personal Use

__Transfer of Care __Other (please specify):_____

**RECORDS TO INCLUDE**

This authorization pertains to the disclosure of the record types indicated below between the following dates of service: from_____ to_____

OR ____ALL records retained by facility

__Progress notes __Laboratory notes __Immunization records __Operative reports

__Hospital records __Imaging reports __Other specified information: _____

**DISCLOSURE OF SENSITIVE INFORMATION**

*I understand that my health record may contain sensitive information relating to my condition(s). this includes, but is not limited to, information pertaining to sexually transmitted disease, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), behavioral or mental health services and treatment for alcohol and drug abuse.*

By checking here, I choose to exclude the above types of information from this disclosure. ___

**TERMS AND CONDITIONS**

- I have the right to revoke this Authorization, in writing, at any time by notifying the Office Manager at Quad Cities Pediatrics, P.C. and the health care provider being requested to disclose health information (if applicable). Such revocation will not apply to information that already had been disclosed in reliance on this Authorization.
- I have the right to not sign this Authorization. Quad Cities Pediatrics, P.C. will not condition treatments, payment for services or enrollment or eligibility for benefits on whether I sign this Authorization.
- If health information is disclosed to a person who is not covered by federal or state confidentiality laws, there is the potential for this information to be subject to re-disclosure and no longer be protected by these laws.
- I have read and understand this Authorization, have had an opportunity to have my questions answered, have signed this Authorization freely and have received a copy of this Authorization if desired.
- Please note, this authorization expires (1) year after the date of signature unless otherwise specified: _____

**SIGNATURE:_____ DATE:_____**

**PRINT NAME:_____ SIGNATURE BY: ___Patient ___Parent ___Legal Guardian**