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 Quad Cities Pediatrics, P.C. Please complete one form for each physician's office from/to which you would like your records transferred.

PATIENT AUTHORIZATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____ Male_____ Female_____

Home Address: _____

City: _____ State: _____ Zip: _____ Fax: _____

Phone: _____

FROM/TO (Please circle intended direction)

Quad Cities Pediatrics, P.C. 5510 Utica Ridge Rd Suite 100 Davenport, IA 52807

Phone: 563-424-2025 Fax: 563-424-2042

FROM/TO (Please circle intended direction)

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

Fax: _____ Phone: _____

PURPOSE OF DISCLOSURE

__Continuing Care __Transfer of Care __Insurance __Legal __Personal Use __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 __Hospital records __Laboratory notes

__Imaging reports __Immunization records __Operative 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

Quad Cities Pediatrics, P.C.