



## RECORDS RELEASE AUTHORIZATION (INCOMING PATIENTS)

I AUTHORIZE:

Previous Healthcare Provider: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

TO RELEASE PROTECTED HEALTH INFORMATION TO REIS PEDIATRICS.

PLEASE SEND:

All Healthcare Information

Immunization, growth, well visits only.

Immunization Record Only

Consultation Note(s) Date(s) \_\_\_\_\_

For the following patients:

Child/children's name(s) and date(s) of birth: \_\_\_\_\_

\_\_\_\_\_

Parent's name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**This Authorization will expire 90 days after the date identified above.** You can cancel this authorization at any time, but you must do so in writing. If you cancel it, the people authorized to use and disclose your protected health information may use the information collected prior to the date you revoked this authorization. Please send written revocation to the individual or department who you authorized to use your protected health information. Also, please be aware that once we disclose this information per your instructions, the information is subject to re-disclosure and may no longer be protected.

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NOTE: WHEN THIS FORM IS COMPLETED, PLEASE DO NOT SEND IT TO REIS PEDIATRICS. MAIL THIS FORM TO YOUR PREVIOUS DOCTOR TO HAVE THE RECORDS COPIED AND SENT TO OUR OFFICE. THANK YOU.