Medical Records Release Form

This form must be completed by the parent/guardian if the patient is a minor. If the patient is 18 years or older, this form must be completed by the patient. To ensure that your/ your child's medical records are held in the utmost confidentiality, please be as explicit as possible as to where you want them sent.

Self (if 18 and older)/ Child #1: _____ _____
Full Name Date of Birth

Child #2: _____ _____
Full Name Date of Birth

Child #3: _____ _____
Full Name Date of Birth

Child #4: _____ _____
Full Name Date of Birth

Your Address: _____
Street City State Zip Code

Your Phone number: _____

Please transfer my/my child's medical records as follows:

From: Grace Pediatrics
4902 Irvine Center Dr. Ste 102
Irvine, CA 92604
Tel) 949-757-3690
Fax) 949-596-9146

To: Office/Physician name: _____
Address: _____
_____
Tel) _____
Fax) _____

***Records to be released:** Unless additional records are requested by your physician, we will send Immunization Records, Problem List/Medical Summary, and Labs/Imaging Studies. Please note that we are not able to send records from specialist visits. Any records from specialist visits must be requested directly from the specialist.

I understand that my/my child's medical records are protected under state and federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections (including testing or treatment for HIV/AIDS), and diagnosis of mental illness or psychiatric care cannot be released without my written consent.

Please initial below if you **DO NOT** want any of the following records released. All applicable records will be released if nothing is marked.

_____ Drug and/or alcohol abuse, diagnosis or treatment
_____ HIV/AIDS testing and/or treatment
_____ Psychiatric care and/or mental illness
_____ Confirmed STI test results and/or treatment

This consent can be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 90 days.

_____ _____
Signature Date

_____ _____
Name of person who signed Relationship to patient