PEDIATRIC ASSOCIATES OF WINCHESTER

Medical Records Transfer From

If you would like your medical records shared and or transferred between Pediatric Associates and another physician, please complete this form and submit it to Pediatric Associates. Please complete one form for each physician office from/to which you would like your records shared/transferred.

PATIENT AUTHORIZATION

Last Name:	First Name:	DOB:	Male/Female
Home Address:	City:	State:	Zip:

FROM/TO *(Please circle intended directions)*

Name:			
Address:	City:	State:	Zip:
Phone:	Fax:		

FROM/TO *(Please circle intended directions)*

Name:			
Address:	City:	State:	Zip:
Phone:	Fax:		

PURPOSE OF DISCLOSURE: *charges may apply for reason other than transfer of care (0.50 cents for first 50 pages and 0.25 cents each page after)

□ Continuing Care	□ Insurance	□ Legal	□ Personal Use
□ Transfer of Care	□ Other (please specify)	□ Consultation	

RECORDS TO INLCUDE:

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 specific 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 diseases, behavioral or mental health services and treatment for alcohol and drug abuse.

TERMS & CONDITIONS:

When my information is used or disclosed to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Pediatric Associates of Winchester has acted in reliance upon this authorization. My written revocation must be submitted to Pediatric Associates of Winchester's Privacy officer at 1002-C Amherst Street, Winchester, VA 22601.

SIGNATURE: DATE:

PINT NAME: SIGNATURE BY: □ Parent □ Legal Guardian □ Patient