MEDICAL RECORD RELEASE

PATIENT INFORMATION

Patient Name: ____ Date of Birth: ___/___/_________

Phone Number: (___) _____-_______

Address: ____

RELEASE INFORMATION TO

Name/Facility: ____

Address: ____

Fax Number: (___) _____-_______

☐ I will pick up the copy in person (charge will apply)

SPECIFIC INFORMATION TO BE RELEASED:

- Information to be disclosed:
  ☐ Medical record from this date ___/___/______ to ___/____/______
  ☐ Enter medical record, including patient histories, office notes (except psychotherapy notes), test results (labs), radiology / imaging reports, files, referrals and consults
  Comments: ____

SPECIFIC INFORMATION TO BE WITHHELD:

- To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check mark(s) below indicate(s) that I do NOT permit information of this type, if it exists, to be released. I understand that if I do not check the box, Northwest Hills Pediatrics will release such information about me if it exists.
  ☐ HIV/AIDS infection
  ☐ Genetic Information
  ☐ Mental Health
  ☐ Sexually transmitted diseases
  ☐ Treatment for alcohol and/or drug abuse

SPECIFIC INFORMATION TO UNDERSTAND

- I understand that my records are protected under the federal privacy laws and regulations and under state law, and cannot be disclosed without my written consent except as other specifically provided by law.

REASON FOR RELEASE:

In efforts to better serve our patients, it is important for us to understand the reason that your child/young adult is leaving our practice. Please select the reason below and provider a description as well.

- ☐ Transfer to an adult provider
- ☐ Moving away to: (city)________________________________(state)__________________________
- ☐ Insurance change
  - ☐ Provider not in new network (network name)
  - ☐ Higher co-pay/higher deductible cost
- ☐ Long wait times
- ☐ Management of my child's healthcare

  Comments:____
____
____

- ☐ Unsatisfactory staff interaction

  Comments:____
____
____

- ☐ Other:____
____
____

I hereby request a copy of my medical and billing records, as contained in the designated records set of Northwest Hills Pediatrics ("Practice"), be made available to me, or a copy of provided, consistent with my wishes above. I understand there may be a charge for the copy, which can include the labor costs of preparing the copy, supplies, electronics media, and postage.

THIS FORM MUST BE FULLY COMPLETE BEFORE SIGNING:

____ ___/____/_____

Signature of Patient or Patients Legal Representative Date

____ _________________________________

Print Name of Legal Representative Relationship to Patient