AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

www.brightfuturepediatrics.com • 120 Old Camden Road, Camden, DE 19934 • Phone: 302.883.3266 • Fax: 302.883.3084

Former Provider:	
Name of Provider/Practice	
Address	
Telephone	

I have transferred my child(ren)'s medical care to the practice below and hereby request that my child(ren)'s Protected Health Information in your possession **(the entire medical record)** be sent in electronic or paper format to:

Bright Future Pediatrics, LLC
120 Old Camden Road, Suite B
Camden, DE 19934

Effective Date of Release:		
Patient Name		**Date of Birth**

If you require a different form in order to transfer these records, please send to:

Patient's Present Address	

I understand that the information to be released may include the following conditions if present: drug or alcohol abuse, psychological or psychiatric conditions, HIV or AIDS testing or diagnosis.

This is a one-time authorization and will expire in 365 days. I understand that I may revoke this authorization in writing. If I revoke this authorization, it is not effective to the extent that the practice has already relied on the use or disclosure of the Protected Health Information. I further understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment).

A copy of this authorization may be utilized with the same effectiveness as the original.

Authorized Signature:	**Date:**
Print Name:	**Relationship to Patient(s):**

Received: _____**Chart** _____**Vac Record** **Receive Date** __________ **Received By** ___________________

Processed Date __________ **Processed By** __________________

Medical Records Transfer IN Form 12/08/2014