MEDICAL RECORDS REQUEST/RELEASE

PATIENT'S INFORMATION		
First Name:	Middle Initial:	Last Name:
Date of Birth:		

PREVIOUS PROVIDER INFORMATION	
Name of Previous Provider:	
Address:	
Phone #:	Fax #:

MEDICAL RECORDS REQUESTED
☐ Complete Medical Records
☐ Medical Records for the period from to
☐ Immunization Records only
☐ Other specific medical information as described:

REASON FOR DISCLOSURE	
☐ Transfer of care to another practice	☐ Other

This Authorization will expire 60 days from today's date: ____ / ____ / ____

By signing this release, I authorize the above listed office/ provider to release protected health information as outlined above to Heart to Heart Pediatrics, LLC, Fax: 618-939-0119.

When my child's information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPPA privacy rule. I have the right to revoke this authorization in writing except to the extent that Heart to Heart Pediatrics has acted in reliance upon this authorization (information release prior to revocation). My written revocation will be submitted to: Privacy Officer, Heart to Heart Pediatrics, LLC, 224 Bradford Ln., Waterloo, IL 62298.

I understand that any fees assessed for copying records of the PHI are my responsibility. The recipient of this PHI will also require consent of patient, parent or legal guardian for further release. I understand that I/my child will not be denied treatment if I do not sign this requested use and disclosure of PHI.

Printed Name of Parent/Guardian:	Relationship:
Signature of Parent/Guardian:	Date: