Cape Cod Pediatrics
P. O. Box 549, Forestdale, MA 02644
Phone: (508) 477-5306
Fax: (508) 477-0297

Authorization to Transfer Medical Records

Patient Name:_____
Date of Birth:_____

I authorize:

_____ **or** Cape Cod Pediatrics
_____ P. O. Box 549
_____ Forestdale, MA 02664
_____ Phone: (508) 477-5306
_____ Fax: (508) 477-0297

To release my records to:

Cape Cod Pediatrics **or** _____
P. O. Box 549 _____
Forestdale, MA 02664 _____
Phone: (508) 477-5306 _____
Fax: (508) 477-0297 _____

Reason for request of records:

____ I am transferring my child **TO** Cape Cod Pediatrics.
____ I am over 18 and am requesting transfer of my own records.
____ I am the parent/guardian and am requesting the transfer of my child's records:
____ Moving ____New Insurance ____Dissatisfaction
____ Other _____

_____Please include entire medical record including office notes (except psychotherapy notes), test results, radiological studies, consults, and records sent to you by other health care providers.

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, Cape Cod Pediatrics will release such information about me if it exists;

__HIV/AIDS __Sexually transmitted diseases __ Mental Health __Genetic information __Treatment for drugs/Alcohol

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.
Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

Signed: _____ Date: _____

Printed Name: _____