



ENGLISH ROAD PEDIATRICS & ADOLESCENT MEDICINE

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AUTHORIZATION FOR RELEASE of MEDICAL RECORDS

PURPOSE OF THIS REQUEST:

I am transferring care to Dr.: _____

Reason: _____

I authorize ENGLISH ROAD PEDIATRICS to:

SEND My Medical Records to:

OBTAIN My Medical Records from:

Physician's Name: _____

Practice Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

I authorize the release of copies of the following medical records, if such information exists:

SPECIFIC INFORMATION AUTHORIZED (select one or more as appropriate):

<input type="checkbox"/> Assessments	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Laboratory Test Results: _____
<input type="checkbox"/> Diagnostic Impression	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Diagnostic Test Results: _____
<input type="checkbox"/> Treatment Plans	<input type="checkbox"/> Educational Information	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Immunizations	_____	
<input type="checkbox"/> Treatment summary (include history/physical, laboratory tests & x-ray reports)		
<input type="checkbox"/> Entire copy of the inpatient/outpatient record checked above.		

This information may be released by:

Copy Court Testimony Electronic Means Fax

Verbal Means Other: _____

I understand that:

- ◆ This authorization will expire one year from the date above unless otherwise stated.
- ◆ I may cancel this authorization at any time by submitting a written request to the English Road Pediatrics address above, except where a disclosure has already been made in reliance on my prior authorization.
- ◆ There may be a charge for the request of copies of medical record information.

By signing below, I acknowledge that I have read and understand this Authorization.

Patient Name: _____ D.O.B: ____/____/____ SEX: M / F

Address: _____ City/State/Zip Code: _____

Cell: (____) ____-____; Phone Number: (____) ____-____; Email: _____

Signature: _____ Relation to Patient: _____

Today's Date: ____/____/____