Records Request Form

To have your child's medical records from a previous provider sent TO Children's Medical Group, complete form below.

SELECT OFFICE:

☐ **Airport Office**
3920 Airport Blvd | Mobile, AL 36608
(251) 342-3810

☐ **Providence Office**
610 Providence Park Dr | Mobile, AL 36695
251-639-1300

PATIENT DETAILS

Name _____ SSN/Health Record # _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____ Phone _____

CURRENT PROVIDER DETAILS*

**The party responsible for releasing the records to Children's Medical Group*

I authorize _____ *to use or release my health information as described below.*

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

RECORDS TO RELEASE

Please identify the information to be released:

☐ **Please release my entire record** **-OR-**

☐ **Please release only the following information:** *(check appropriate boxes and include other information where indicated)*

☐ Problem List ☐ List of Allergies ☐ Immunizations ☐ Medication List

☐ Office Notes _____ ☐ History & Physical _____ ☐ Discharge _____ ☐ ER _____

☐ Lab Results _____ ☐ X-ray and Imaging Reports _____ ☐ Consultation Reports _____ ☐ Other *(please describe)* _____

The identified information will be used for the following purpose:

☐ **Change to another pediatrician** ☐ **Attorney/Legal** ☐ **Other** *(please specify)* _____

☐ **My personal records** ☐ **Continued care** *(consult/referral)*

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Records Request Form

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Please initial each item below to indicate your understanding.

(Initial) I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

(Initial) I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

(Initial) I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

(Initial) I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be used by or released to the following individual(s) or organization(s): *(check one)*

☐ **Children's Medical Group, P.A. (Airport)**
3920 Airport Boulevard, Suite-A
Mobile, Alabama 36608
(251) 342-3810 (P)
(251) 344-6752 (F)

☐ **Children's Medical Group, P.A. (Providence)**
610 Providence Park Dr, Suite 201
Mobile, Alabama 36695
(251) 639-1300 (P)
(251) 639-1380 (F)

This authorization will expire on _____ *(insert date or event)*: ***If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.***

Patient Signature / Parent / Legal Guardian | Relationship | Date (MM/DD/YYYY)

Witness Signature | Date (MM/DD/YYYY)