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Approval for Release or Transfer of Records

Parents' or Guardians' Name: _____

Child's Name	DOB

I authorize Grow With Me Pediatrics LLC to [obtain / release] (circle one) the following information below.

_____ Entire Medical Record
_____ Immunization Record and last physical notes

Purpose of releasing or transferring records

_____ Transfer of Care
_____ Moving
_____ Change of Insurance
_____ Other, please specify

Location of where records are being released from:

Name of Practice _____
Address _____
Phone / Fax _____

Signature of Patient / Parent / Guardian _____
Date _____

By signing this document, I understand that release of records may include notes that include information about HIV/ AIDs, drug, or alcohol abuse, or that of psychological in nature. I consent to disclosure of such information. All records remain confidential. If I choose not to disclose information of that nature, I understand I can revoke authorization in writing at any time. I understand that this authorization is valid for 60 days from the date of signing.