Medical Records Release Form

From Tosa Pediatrics

I authorize Tosa Pediatrics to release the records for the following patient(s) for the purpose of transfer:

Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____

Phone: _____

☐ mailed to the address below ($10 fee per patient):

_____

☐ in person when called at the number below ($5 fee per patient):

_____

Reason for transfer:

_____

There is a $5 fee per patient for records pickup and a $10 fee per patient for records to be mailed.

I, the guardian/parent/patient authorize the release of all medical records for the above listed patient in accordance with the specification listed above. I understand that I have a right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as the original.

_____ _____

Printed Name Relationship

_____ _____

Signature Date