



# Authorization to Release Medical Records

By filling out this form, I, \_\_\_\_\_, being the patient, parent, or legal guardian of the patient, do hereby request Dakota Pediatrics, P.A. to release medical records as specified by the form below.

<b>CLINIC OR PHYSICIAN TO RELEASE RECORDS TO:</b>		
Clinic Name or Physician Name:		
Address:		Fax or Email:
City:	State:	Zip Code:
<b>MEDICAL RECORDS TO BE TRANSFERRED:</b>		
Type of Release:		
<input type="checkbox"/> All records relating to _____ (please specify) <input type="checkbox"/> Entire Patient Record		
Reason for Release:		
<input type="checkbox"/> Change of Insurance <input type="checkbox"/> Personal Use (*You may be charged for these records*) <input type="checkbox"/> Consult/Second Opinion <input type="checkbox"/> Change of Physician (unhappy with care at Dakota Peds) <input type="checkbox"/> Moving Out of Town <input type="checkbox"/> Change of Physician (happy with care at Dakota Peds)		
If you answered that you were unhappy with your care at Dakota Pediatrics, can we contact you for additional feedback? <span style="float: right;"><input type="checkbox"/> Yes      <input type="checkbox"/> No</span>		
Patient Name:	Date of Birth:	
Patient Name:	Date of Birth:	
Patient Name:	Date of Birth:	
Patient Name:	Date of Birth:	

This authorization is valid for up to one (1) year after my signature appears on this form and authorizes the release of the patient records up to and including the date of this release. I may revoke this authorization at any time except to the extent that the records have already been released. Any re-disclosure of this information, depending on the nature of the information, may not be permitted without my specific authorization.

Patient, Parent, or Legal Guardian Signature:	Date:
Address:	Phone: