SPRING HILL
Pediatric Care

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

(This authorization complies with HIPAA)

Patient Name: _____ Date of Birth: _____

Facility/Office to release records (PREVIOUS DOCTOR'S OFFICE):

_____

Address: _____

Phone: _____ Fax: _____

I hereby authorize Spring Hill Pediatric Care access to my medical records. These records are being requested to assist in the continuity of my patient care at Spring Hill Pediatric Care.

I understand that I may revoke the authorization at any time, and in order to do so, I must send written notice to the healthcare provider(s).

Medical Records to be released:

- **Please send last two Well Visits and last two Sick Visits and a copy of their Immunization Records.**

*A copy, electronic copy, image, or facsimile of this authorization is as valid as the original.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Signature: _____ Date: _____