Manchester Pediatric Associates LLC
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Authorization of Release of Health Information

What information are we disclosing to the new practice?

- ❑ Entire Medical record
- ❑ Immunization record
- ❑ Last physical Exam Notes
- ❑ Lab results

Are you transferring out of Manchester Pediatrics and terminating your patient status here?

○ **YES** ○ **NO, just information**

Patient Information

Patient's first name: ______________________ Last name: ______________________

Date of birth: ______________________

Patient's first name: ______________________ Last name: ______________________

Date of birth: ______________________

Option A

I, ______________________ authorize Manchester Pediatric Associates to disclose protected health information to the following organization:

Doctor's office name: ______________________

Address: ______________________

Telephone: ______________________ Fax: ______________________

How would you like the medical records to be released to the new facility

- ❑ Copies by mail (50 cents per page)
- ❑ Copies by fax
- ❑ Burned to a CD ($5)

Option B

I, ______________________ authorize Manchester Pediatric Associates to disclose protected health information to ***myself/responsible party of patient above***

I understand that I may refuse to sign this authorization and that the health center may not condition my treatment based on this authorization. I understand that MPA will charge me 50 cents per page for any printed records and a flat fee of $5.00 for any CD. I may revoke this authorization at any time by written request except when the information has already been released based on my authorization. This authorization is valid for one year after the date it has been signed.

______________________ ______________

Signature of Parent/Responsible Party Date