

Long Pond Pediatrics, LLP

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Record Release Form

I authorize Dr. _____ of Long Pond Pediatrics to:

_____ Release my medical records to: * _____ Obtain my medical records from:
*LPP accepts new patient records via mail or thumb drive only.

Name: _____

Address: _____ Zip Code: _____

Must include Fax Number: _____

_____ I am transferring care to the above doctor **OR** _____ Copy of record for review not transfer

MUST INITIAL EACH ITEM AUTHORIZED TO SEND

_____ **All Records** _____ **Selected Items:** Specify below (ex: lab results)
_____ **All Records including:**
_____ **Mental Health/Drug/Alcohol Treatment** _____
_____ **HIV/AIDS** *Must Sign Separate Release _____

This Release Applies to: (Please note: Patients 18 years of age or older must sign individually)

Patient Name	DOB	Relationship to Signer

X _____
Signature of Patient (18yr and older) / Parent / Guardian Date

Printed name of Patient / Parent/ Guardian Date

Address and telephone number of Person Signing Form

*Please note: A copy fee of \$.75 per page plus postage is charged for medical records. To avoid this fee we complete and fax or mail a detailed summary report including pertinent chart information.

Reason for transfer: ___ Released ___ Moved ___ Age ___ Dissatisfied, please explain: