Long Pond Pediatrics, LLP

3 Saredon Place, Suite 100, Rochester, NY 14606 P: 585-225-0950 F: 585-225-9093

Record Release Form

I authorize Dr. _____ of Long Pond Pediatrics to:

_____ Release my medical records to: _____ Obtain my medical records from:

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**
____ **All Records including:**
Mental Health/Drug/Alcohol Treatment
____ **HIV/AIDS** *Must Sign Separate Release

____ **Selected Items:** Specify below (ex: lab results)
_____
_____

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:

_____

_____