Please check here if

Patient is NOT transferring out

Long Pond Pediatrics & Osteopathy, P.C.
110 Long Pond Road Ste. 211
Plymouth, MA 02360
Phone: 508-747-1663 Fax: 508-747-5581

Please fax record to:
Dr: _____
Fax: _____
Phone: _____

WRITTEN CONSENT TO RELEASE/TRANSFER MEDICAL RECORDS

***** PLEASE NOTE *****
MEDICAL RECORDS CANNOT BE PRODUCED UPON DEMAND
NORMAL PROCESSING TIME IS 7-21 BUSINESS DAYS

PLEASE PRINT CLEARLY

Today's Date _____/_____/_____

Patients(s) Name: _____ DOB: _____
_____ DOB: _____
_____ DOB: _____
_____ DOB: _____

Address: _____

_____

Telephone # Home: _____ Cell: _____

Our policy requires that all medical records to be released are to be picked up at our office or are faxed directly to your new provider. Your medical records will be prepared as requested and when available, a member of our staff will contact you by telephone.

Reason for transfer (please circle)

Age Moved Prefer Male MD Insurance Other, please explain _____

**** Standard policy is to provide a clinical summary, a copy of immunizations and growth charts. In circumstances when a copy of an entire medical chart is required, a fee of not less than $25 is required.****
Checks should be made out to Long Pond Pediatrics & Osteopathy, PC

I, _____ hereby consent to the disclosure or transfer of my medical records. I also hereby release Long Pond Pediatrics & Osteopathy, PC and all personnel from any liability in connection with such disclosure or transfer. This consent is subject to revocation at any time, except to the extent that action has been taken by Long Pond Pediatrics & Osteopathy, PC and all personnel in good faith.

I understand my specific consent is required to disclose sensitive information. Please circle **DO** or **DO NOT** to authorize release of the following information:

DO	**DO NOT**	release information which refers to treatment and/or diagnosis of drug or alcohol abuse
DO	**DO NOT**	release information which refers to treatment and/or diagnosis of Mental Health illness and/or issues
DO	**DO NOT**	release information which refers to HIV test results and/or infection status
DO	**DO NOT**	release information which refers to STD test results and/or infection status
DO	**DO NOT**	disclose other information as specified here: _____

_____

Signature of patient (parent or guardian if under 18) Date

Please note: All information must be filled in completely before any release of records will be done. An incomplete form **WILL NOT** be processed. Thank You.