Carolyn R. Ganeles, M.D.
Scott M. Kallor, D.O.
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AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

Patient name: ______________________________ **DOB:** ______________________

Patient name: ______________________________ **DOB:** ______________________

Patient name: ______________________________ **DOB:** ______________________

Patient name: ______________________________ **DOB:** ______________________

Address: ____

Telephone: ________________________

I hearby authorize Pediatric Partners LLC to: Release Obtain (Circle one)

Name of practice: ____

Practice address: ____

Practice phone: ____________________________ **Fax:** ______________________

Records authorized to be released/obtained:

Complete health record

Last 3 physical exams, vaccination records, growth charts, ALL office visits, lab & diagnostic tests, and correspondence in the past 24 months

Medical summary, vaccination records, growth charts, and most recent physical exam

Hospital reports: Specify date(s): ________________________

Admission H&P Discharge summary ER visit Lab & diagnostic tests

Outpatient reports (ie. Specialists)

Urgent care

Other: ____

Reason for transfer: (**ie: Moving, continuity of care, etc**)

____

I understand the requested information may contain protected health information related to mental health, developmental disabilities, substance abuse, sexually transmitted diseases, and HIV testing. I understand that the released information may be re-disclosed upon written authorization to Pediatric Partners LLC to disclose medical information. I understand I may revoke this authorization in writing at any time.

Patient/Guardian name printed: ______________________________

Relationship to patient: ____________________________________

Signature: ____________________________ **Date:** ______________________

Expires 12 months from date

DON'T FAX RECORDS CONTAINING MORE THAN 10 PAGES