Authorization to Transfer/ Copy/ Inspect Health Information

(*Please check the appropriate box*)

☐ Transfer Records

☐ Copy Records

Date: _____

Patient's Name: _____

Patient's Birth Date: _____

I hereby authorize SOUTH EAST BAY PEDIATRIC MEDICAL GROUP to TRANSFER all health information relating to my child's care.

There is a $6.25 flat rate for a release for records

☐ I am only requesting a copy of the records concerning : _____

To My **MYCHART** account : _____

To be Mailed to My **NEW PHYSICIAN OR OTHER ENTITY** at the following address:

Name:_____

Address: _____

City, State, Zip Code:_____

Phone Number: _____

The reason for my request is:_____

(please specify)

Parent Signature:_____ date _____

(*Required for patients under 18 years of age*)

Parent Name:_____

Patient Signature: _____

THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE ABOVE DATE.

I do not have to sign this authorization to receive treatment from South East Bay Pediatric Medical Group. I have the right to refuse to sign this authorization. After my information is transferred or disclosed to the physicians or entity above, it may be transferred or disclosed again by the physician or entity listed above. In that situation, it may no longer be protected by federal HIPAA Privacy Rule. I have the right to revoke this authorization. If I revoke this authorization, no further transfer or disclosure of my information will occur. *Any information that has been transferred or disclosed after the date of this authorization, but before the date of revocation, will not be affected by the revocation.*My revocation must be submitted in writing to the Privacy Officer at:

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