Medical Records Transfer Form

If you would like medical records transferred between **Sandpiper Pediatrics** and another physician, please complete this form and submit it to our office. Please complete one form for each physician office from/to which you would like records transferred

Patient Authorization

Last Name:	First Name:		MI:
Date of Birth:	O Male O Female		
Home Address:	City:	State:	Zip:

From/To (Please circle intended direction)

Name:			
Address:	City:	State:	Zip:
Phone:	Fax:		

From/To (Please circle intended direction)

Name: Sandpiper Pediatrics			
Address: 27417 Andrew Jackson Highway East	City: Delco	State: NC	Zip: 28436
Phone: (910) 207-0777	Fax: (910) 202-6312		

Purpose of Disclosure

O Transfer of Care	O Continuing Care	O Insurance
O Legal	O Personal Use	O Other (please specify):

Records to Include:

This authorization allows for disclosure of the following record types for the date range of: _____ (mo/yr) to _____ (mo/yr)

O All Records	O Progress Notes	O Laboratory Results
O Immunization Records	O Operative Reports	O Hospital Records
O Imaging Reports	O Other specified information:	

Disclosure of Sensitive Information

I understand that my health record may contain sensitive information relating to patient's conditions. This includes, but is not limited to, information pertaining to sexually transmitted disease, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), behavioral or mental services and treatment for alcohol or drug abuse.

By checking this circle, I choose to **exclude** the above types of information from this disclosure. O

Terms and Conditions:

- I have the right to revoke this Authorization, in writing, at any time by notifying Sandpiper Pediatrics. Such revocation will not apply to information that has already been disclosed in reliance of this Authorization.
- I have the right not to sign this Authorization. Sandpiper Pediatrics will not condition treatments, payment for services or enrollment or eligibility for benefit on whether I sign this Authorization.
- If health information is disclosed to a person who is not covered by federal or state confidentiality laws, there is potential for this information to be subject to re-disclosure and no longer be protected by these laws.
- I have read and understand this Authorization, have had the opportunity to have my questions answered, have signed this Authorization freely and have received a copy of this Authorization.
- Please note, this Authorization expires one (1) year after the date of signature unless otherwise specified: _____
- **I understand that submitting this Authorization to Sandpiper Pediatrics will not terminate the patient's relationship to the practice**

Signature:_____ **Date:_____**

Print Name:_____ **Signature By: O Patient O Parent O Legal Guardian**