Drs. Concannon & Vitale LLC
Pediatrics & Adolescent Medicine
1145 Reservoir Avenue, Suite 124
Cranston, RI 02920-6055

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OUT

MEDICAL RECORDS TRANSFER AUTHORIZATION

To: (New Physician & Address)

From:

Drs. Concannon & Vitale LLC
1145 Reservoir Avenue, Suite 124
Cranston, RI 02920-6055

Name1: _____ Date of Birth: ____/____/____

Name2: _____ DOB: ____/____/____

Name3: _____ DOB: ____/____/____

Name4: _____ DOB: ____/____/____

Address _____ City _____ State _____ Zip _____

I hereby authorize the disclosure and/or transfer all medical records covering the period from birth to present, for the purpose of providing continuing medical care for my children or myself as listed above. This information to be disclosed will include all information, inclusive of alcohol, drug abuse, HIV testing, psychiatric notes, venereal disease and/or other sensitive information.

Medical information is protected under law and, except as provided by law, cannot be disclosed without written consent. Information released with this authorization must not be given, sold, transferred, or in any way relayed to any other person or entity not specified above. When medical information is transferred, the sender cannot necessarily prevent further disclosure by the recipient under HIPAA privacy rules. This authorization may be withdrawn at any time by submitting a written revocation to the sender.

Medical Records Charges Due from Parent or Patient: **$**_____

_____ _____
Printed Name of Parent/Guardian/Patient Relationship to Patient(s)

_____ _____/_____/_____
Parent/Guardian/Patient Signature Date

Comments: