REQUEST FOR TRANSFER OF MEDICAL RECORDS

Authorization for use/disclosure of information: I voluntarily authorize and direct Drs. Klausner, Efron, and or Shaham to disclose my health information to the recipient that I have identified below:

Please send copies of the entire medical records to our new provider:

Doctor's name: _____

Address: _____

Phone/Fax: _____

This authorization is:
( ) Unlimited – All Records
( ) Limited to the following medical information: _____
and/or dates: _____

Permissions for further use of disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

Child's Name: _____

Date of birth: _____

Names of additional Children:

_____

I agree to pay any fees for copying and or summarizing my protected health information. I have been advised of my right to receive a copy of this authorization:

_____ _____
Parent / Guardian's Signature **Date**