FamilyWellnessMD
Healthy Families. Healthy Kids.

Authorization to request medical records

Please transfer All medical Records of the following patient:

Name _____ Date of Birth _____

From Family Wellness MD

To:

Name of Clinic: _____

Address: _____

_____

Phone Number: _____

Fax Number: _____

*By signing below you understand that once this facility discloses your child's health information by your request, you cannot guarantee that recipient will not re-disclose my child's health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state laws governing the use of disclosure of your child's health records. You may make a request in writing at any time to inspect and/or obtain a copy of your child's health information maintained at this facility as proved in the Federal Privacy Rule 45 CFR (164.524). Your child's records are protected and cannot be disclosed without written permission . This authorization will remain in effect for one year as of the date it was signed.

Signature_____**Date**_____

Relationship to patient_____