Amanda R. Lloyd, MD

Authorization for Release of Medical Records

Purpose of this request: I am transferring care to Dr._____

I authorize Bright Steps Pediatrics to: ___ send my medical records to:

___ obtain my medical records from:

Physician's Name_____

Address_____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

I authorize release of:

_____Release immunization records only

_____Release info from the most recent physical exam only

_____Release records including growth charts, immunizations, allergies, current medication list, labs, x-rays, specialist reports for last 12 months, most recent physical and last 3 office visits

_____Release all records

_____Release all records EXCEPT alcohol/drug related information

_____Release all records EXCEPT mental health related information

By Law – All HIV/AIDS-related information requires a separate authorization form.

Records within the chart from other medical providers will not be transferred.

I understand that:

- This authorization will expire 1 year from the date above unless otherwise stated.
- I may cancel this authorization at any time by written request, except where a disclosure has already been made on my prior authorization.
- There may be a charge for the request of medical record information.

By signing below, I acknowledge that I have read and understand this authorization.

Patient Name _____Date of Birth _____

Signature of parent/patient (if over age 16 years)_____

Parent Name _____ Today's Date _____