Healthy Horizons Pediatrics

Helping Your Children Grow!

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(732) 432-7337 – www.hhpeds.com – admin@hhpeds.com

Medical Records Transfer Request

Patient Name: _____Date of Birth: _____ Telephone:_____

I authorize the following organization to release information as detailed below from the patient health information record:

Information To Be Released From:	**Information To Be Released To:**
	Healthy Horizons Pediatrics PA 620 Cranbury Rd, Suite 207 East Brunswick, NJ 08816 Fax #: 732-432-7338

For most ***Healthy*** Children, we will not require the complete medical record from your previous health care provider. We suggest initially:

☐ ***Limited*** transfer of Medical Records to include the following information:

- Problem List, Medication List, Allergies (Include both Electronic and Paper)
- Chart notes for past ***12 months*** (Include both Electronic and Paper)
- Vaccination record, Growth charts
- Outside notes / Correspondence
- Lab & Radiology Reports

If your ***Child has more Complex Medical Problems***, please check the box below to request his or her ***complete*** medical record.

☐ ***Complete*** Medical Record

We will review your child's outside medical records, input and scan pertinent information.

My signature below indicates my consent to authorize any physician, nurse, other health professional or an authorized representative to release any/all medical information and/or records which may be requested regarding patient health information.

____ (initial) I authorize the release of psychiatric/psychotherapy records, mental health records and drug/alcohol treatment records under the same conditions.

My signature below authorizes Healthy Horizons Pediatrics PA, or an authorized representative, to receive photocopies of all medical records, charts, notes and other information relating to the general physical condition of the patient listed above. I authorize release of this information to the above location for the purpose of continued medical care; and I allow them, or any physicians appointed by them, to examine this information. I understand that this consent is subject to revocation at any time by notification in writing, except to the extent the Healthy Horizons Pediatrics PA has already acted in reliance of this release.

_____ _____ _____

Signature Date Relationship to Patient