Edgewood Center Pediatrics, P.C.
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Commerce, MI 48382
Ph – (248) 360-9241
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RECORD RELEASE FORM

Name of Patient(s) Date of Birth

_____

_____

Records to be sent to: From:

_____ _____

_____ _____

_____ _____

These records are being released for the following reason(s):

__ Moving to new area
__ Transferring to a doctor in the area (patient has outgrown pediatric age)
__ Changing insurance, If so please list_____
__ Seeing a specialist
__ Insurance company request
__ Transferring to a new pediatrician due to dissatisfaction with:
- __ Waiting time in office
- __ Pediatrician's care of child
- __ Interaction with staff
- __ Difficulty scheduling timely appts
- __ Other (please comment below)

_____

_____

I authorize the medical release of these records including immunization records, HIV testing results, Mental health/Chemical dependency, and any infectious diseases.

Signature (Parent or Guardian): _____

Date: _____