Medical Records Release

Please complete the following form to authorize New Beginnings Pediatrics to send records to another office. If you are a previous NBP patient, please see our website for the specific form to request records from APCA for services rendered before March 2024.

Patient Name:_____ Date of Birth:_____

I, _____ (parent/guardian), authorize New Beginnings Pediatrics to release my/my child's records to the following person, physician or organization:

Physician/Organization Name: _____
Physician/Organization Address: _____
_____
Physician/Phone Number: _____
Physician/Organization Fax Number (REQUIRED:) _____

Portion(s) of records to be released include (please check desired items to be released):

- __ **COMPLETE Medical Record**
- __ Vaccination Record Only
- __ Office Notes Only
- __ Labs/Studies Only
- __ Radiology Reports Only
- __ Sensitive Information (examples include: STD Testing, HIV testing, psychiatric records, etc)
- Other (please explain):_____
_____
_____
_____

This purpose of this disclosure is:

- __ Personal Records
- __ Continuity of Care
- __ Transfer of Care
- __ Other: (please explain) _____
- __ Insurance Processing
- __ Legal

I understand that my records are confidential and may be disclosed only as authorized in this consent or as required by law. I also understand that this is revocable by me at any time except that action has been taken in reliance on this consent. Unless otherwise specified below, this consent will automatically expire after one year from the date above.

Signature: _____ Date: _____
Relationship to patient: _____ Request consent to expire: _____

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