

**RIDGEFIELD PEDIATRIC ASSOCIATES, P.C.
MEDICAL RECORD TRANSFER FORM**

NAME: _____ DOB _____ LAST VISIT _____

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REASON FOR TRANSFER:

- ___ DISSATISFIED(reason) _____
- ___ INSURANCE CHANGE(name of new insurance) _____
- ___ MOVED(new address and phone) _____
- ___ ADULTHOOD(new doctor) _____
- ___ OTHER _____

By completing and signing this transfer request, I release Ridgefield Pediatric Associates, P.C., from any further medical responsibility for my child/children. I understand that I am responsible for picking up these records or supplying the name and address of a new physician so that they may be mailed. HIPAA regulations require special authorizations to release medical records. If you need your records mailed, you must fill out the Release of Patient Information Form. In either case, so that we can be assured of the child's continued medical care, please provide new physician information below.

Name and Address of New Physician: _____

Please Note: *State of Connecticut Privacy Laws require that if this request is for any child 13 years of age or older, this form must be signed by that child in addition to a parent or guardian, since there may be confidential information that the child does not wish shared by anyone other than their physician.*

Ridgefield Pediatrics will adhere to the HIPAA Privacy Act regarding age requirements for our patients. Patients age 13 years and older must give permission for their parents to receive their medical chart. Patients age 18 are considered adults and must pick up their own medical record.

Parent or Guardian / date

Child 13 years or older / date

Signature(s) Required