Request for Transfer of Records

I hereby authorize:

Name of Medical Practice: _____

Address: _____

_____

Phone: _____Fax*:* _____

to release ALL medical records including immunizations, labs and x-rays, growth curves, and newborn records (if applicable) for:

Patient Name:_____Date of Birth:_____

Patient Name:_____Date of Birth:_____

Patient Name:_____Date of Birth:_____

To: *Acorn Pediatrics*
Dr. Sheila Idzerda, MD
Dr. Courtney Handlin, DO

1819 S. 22nd Avenue, Suite 100
Bozeman, Montana 59718

Fax: (406)414-0274
Phone: (406)522-5437

By signing this authorization, I give permission to release and transfer my child's protected health information (PHI) to the above requesting provider(s) for the purpose of treatment and/or transfer of care. I understand that this authorization is in effect for one year from the date signed.

Signature of Parent: _____Date: _____

Printed Name: _____Relationship to Patient: _____