

**MICHELLE BENNETT, M.D., MPH \* KRISTIN GRIMES, M.D.\* JOANNE DONAHUE, F.N.P.**

**175 Nate Whipple Hwy, Suite 102, Cumberland, RI 02864 P: 401-334-KIDS F: 401-334-3571**

**For patient’s transferring TO the practice:**

Please complete the medical request form to obtain the patient’s medical record from the previous MD. In order to provide you with the best care possible, we require the COMPLETE medical record BEFORE an appointment is scheduled. Please allow up to 30 days for your prior doctor’s office to forward medical records to us. If there are concerns with the time frame of records being received, we encourage you to contact the previous office directly.

Please have records forwarded to:

**NRI Pediatrics, PC**

**175 Nate Whipple Hwy, Suite 102**

**Cumberland, RI 02864**

**For patients transferring FROM the practice:**

To obtain a copy of your child’s medical records, please complete the enclosed medical release form and return it to the office.

Please note that there is a $15.00 processing fee for each child’s record. Additional fees may apply when a record has to be retrieved from storage, or if a record needs to be mailed. When you return the signed authorization form, we ask that you remit payment at that time. Records will not be copied until payment is received. We accept cash or credit card as methods of payment for records. If you would like to pay by credit card you may complete the credit card information section below and return this letter to us. You can also call in the payment if you prefer.

We will process your request as soon as we can, but please note that it may take up to 30 days.

We encourage you to pick up your child’s records rather than having us send them to a medical facility or office. By doing this, we avoid loss of records in the mail, and you will be able to make a copy of the records to keep for yourself. Please call the office if you have any questions.

***Credit Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Exp. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ CVC Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Signature of cardholder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***



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**Authorization to Release and/or obtain confidential information**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent or guardian’s name (if under 18):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Northern Rhode Island Pediatrics to:

[ ]  Release to

[ ]  Obtain from: **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **City/ State**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fax:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please release the following information:**

\_\_\_\_\_\_ All healthcare information (if patient is transferring care) **FROM BIRTH TO PRESENT DAY**

\_\_\_\_\_\_ Patient Summary ONLY

\_\_\_\_\_\_ Healthcare information relating to the following treatment, condition, and dates of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Transfer: [ ]  Changing Physicians [ ]  Continuing Care [ ]  Moved out of State [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I initial the applicable space next to that type of information. I have read carefully or have been read to and understand the above statements and voluntarily consent to disclose the above information and/or medical records to those persons/ agencies named above.

**This includes records pertaining to the following.**

**\_\_\_\_\_ Alcohol/ drug abuse records \_\_\_\_\_ Mental health records \_\_\_\_\_ STD testing and results, including HIV (AIDS) results.**

**\_\_\_\_\_ Records pertaining to pregnancy and or reproductive health \_\_\_\_\_ Genetic Testing**

I further release Northern Rhode Island Pediatrics and its employees from any liability arising from the release of information to such persons/agencies, provided the said release of information is done substantially with applicable law.

I understand that I may revoke this consent at any future time and that it will automatically expire 90 days after it is signed or after they’ve been completed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian Relationship (parent, legal guardian) Date

Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature (if required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_