Riverside Pediatrics, Inc.
50 Amaral Street, East Providence, RI 02915
Phone: (401) 434-8009   Fax: (401) 434-2071

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MEDICAL RECORDS RELEASE FORM

1. I hereby consent to and authorize the release or transfer by Riverside Pediatrics, Inc. of the records of care at this office of:

   Patient Name: ____ DOB: _______________

   Expiration Date:__________________

2. I understand that such medical information is needed for or will be used for:

   ___ Transfer of care ___ Follow-up care
   ___ Change of Physician/telemedicine ___ Other: ____________________________________

3. I request that the medical information be **TRANSFERRED TO**:

   ____

   ____

   ____

4. Information to be transferred:

   ◻ All records generated by Riverside Pediatrics
   ◻ All records generated by Riverside Pediatrics **except the following**:

   ____

   ____

5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand that the revocation will NOT apply to information that has already been released in response to this authorization.

Signature: ____ Date: ____________________