COVE PEDIATRICS, LLC

Request for Medical Records from an Outside Provider

Patient: _____ DOB: _____

Address: _____

_____ is authorized to furnish to:

MEDICAL RECORDS (excluding sensitive information)

- Information and records or copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease Beginning _____ and ending_____and, if necessary, allow them or any physician appointed by them to examine any x-rays or records which the facility may have regarding my condition or treatment during this period.

SENSITIVE INFORMATION

- I hereby consent to the disclosure and release of highly confidential information including; Information about HIV/AIDS status, information about genetic testing, information related to confidential communications with a social worker, sexual assault counselor, domestic violence counselor or other allied mental health professional or human services professional, information about treatment of substance abuse (alcohol or drug), information about venereal disease(s), abortion consent form(s), mammography records, information about family planning services, if I am an emancipated minor, information about treatment and diagnosis(except to my parents), information related to mental health community program records, information about research involving controlled substances.

I release, _____ from all responsibility that may arise from this authorization. I may withdraw this consent by giving written notification to_____ at any time prior to the disclosure or release of information.

_____ _____

Patient signature Date

_____ _____

Witness Signature Date