



# WATCHUNG PEDIATRICS



76 Stirling Road  
Suite 201  
Warren, NJ 07059  
908-755-KIDS (5437)  
908-755-6905 (fax)

225 Millburn Avenue  
Suite 301  
Millburn, NJ 07041  
973-376-PEDS (7337)  
973-218-6647 (fax)

346 South Avenue  
Suite 3  
Fanwood, NJ 07023  
908-889-TOTS (8687)  
908-889-0047 (fax)

[www.watchungpediatrics.com](http://www.watchungpediatrics.com)

## Transfer to an Adult Physician

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information may no longer be protected by federal privacy regulations and that it may be re-disclosed by the recipient.

**Patient (s) Name(s) and Dates of Birth:** \_\_\_\_\_

**Organization Providing the Information:** Watchung Pediatrics, 76 Stirling Rd, Ste 201, Warren, NJ 07059

**Organization or Provider Receiving the Information:** \_\_\_\_\_

Specific Description of Information Disclosed:  Medical History Summary and Immunization Record (no cost)  
 Complete Medical Record  
 Other: \_\_\_\_\_

To the extent any of the following information is contained in my records being released, I specifically authorize the release of such information purposes indicated below by initialing before each category:

**Initials:** \_\_\_\_\_ HIV/AIDS testing, test results; treatment and related information including high risk behavior documented:

**Initials:** \_\_\_\_\_ drug and/or alcohol diagnosis, treatment, test results and reports and referral information;

**Initials:** \_\_\_\_\_ mental health treatment information, test results and reports including psychological and psychological and psychiatric studies, reports, evaluations and referral information; and/or

**Initials:** \_\_\_\_\_ information regarding sexually transmitted diseases;

**Initials:** \_\_\_\_\_ genetic testing, test results, counseling reports, treatment, and referral information.

**Purpose of Discloser:** Transfer adult physician

### You must read and initial the following statements:

1. I understand this Authorization will expire one year from date below OR on \_\_/\_\_/\_\_. This allows the disclosing office to forward any information received to my new provider without requiring a new authorization form to be completed. **Initials:** \_\_\_\_\_
2. I understand that I may revoke this Authorization at any time by notifying the disclosing office's Privacy Officer in writing, but if I do, it will not have any effect on any actions they took before they received the revocation. **Initials:** \_\_\_\_\_

### Charge:

As per NJ Statute, Watchung Pediatrics charges a medical record transfer fee of \$1 per page, with a maximum \$100, *per child*.

When records are copied, and mailed directly to a physician, the maximum charge is \$25 *per child*, payable at the time the request is submitted.

Patients may have a Medical Summary and immunization record *free of charge*.

Please allow 30 business days for your request to be processed.

\_\_\_\_\_  
Signature of Patient or Representative and Relationship  
*You may refuse to sign this authorization. We cannot condition treatment on your signing this Authorization.*

\_\_\_\_\_  
Date

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