# *James A. Weidman, A Medical Corporation*

*Infants, Children & Adolescents*

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**TRANSFER AND RELEASE OF MEDICAL RECORDS TO DR. JAMES A. WEIDMAN**

To Physician: _____
Name

_____
Address

_____
City State Zip Code

I hereby authorize the above Physician to release all confidential medical information and records regarding:

Name of patient: _____ DOB: _____

Name of patient: _____ DOB: _____

Name of patient: _____ DOB: _____

Please release all of the above patients' medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records, including staff messages, mental health diagnosis/treatment, drug/alcohol/substance abuse, HIV diagnosis/treatment. Such records should include those from my other healthcare providers that the above-named Physician may hold, by means of mail, fax, email, or other electronic methods.

A photocopy or facsimile of this authorization shall be considered as effective as valid as the original.

Parent Signature: _____ Date: _____

Print Name: _____