Beach Pediatrics
Medical Records
Transfer Authorization

Please Send Records To: Beach Pediatrics
17742 Beach Blvd. Suite 360
Huntington Beach, CA 92647
Phone: (714) 848-0868
Fax: (714) 848-2248

Purpose of Transfer: To ensure continuity of care at Beach Pediatrics.

Patient Information:

Child's Full Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Address: _____

Phone Number: _____ Email: _____

Current Medical Office (Releasing Records):

Practice Name: _____

Address:_____

Phone: _____ Fax: _____

Records to Release: All medical records (immunizations, labs, growth charts, etc.)

Privacy Acknowledgment

I understand my child's medical records are confidential. Once released, these records may no longer be protected. I hereby authorize the release of the specified records to Beach Pediatrics.

_____ _____

Parent/Guardian Signature **Date**