JELLYBEAN PEDIATRICS, LLC

Authorization to Obtain Medical Records

Version 1.0 • July 2026

Reference Copy

This document is provided so families can review the forms used by Jellybean Pediatrics before enrollment. Official enrollment paperwork will be completed electronically after joining the practice.

Patient Name: _____

Date of Birth: _____

I authorize the following healthcare provider(s), hospital(s), clinic(s), or healthcare organization(s) to release medical records to:

Jellybean Pediatrics, LLC

Previous Provider / Organization:

Name: _____

Phone: _____

Fax: _____

Address (optional): _____

Information Requested

☐ Complete Medical Record

☐ Immunization Records

☐ Growth Charts

☐ Laboratory Results

☐ Imaging Reports

☐ Specialist Records

☐ Other: _____

Purpose of Disclosure

☐ Continuity of Care

☐ Establishing Care with Jellybean Pediatrics

☐ Other: _____

Newborn Option

☐ My child does not yet have prior pediatric medical records.

Authorization

I authorize the release of the records described above to Jellybean Pediatrics, LLC for purposes of medical treatment and continuity of care.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance upon it.

This authorization expires one year from the date signed unless revoked earlier.

Parent/Guardian Signature: _____

Printed Name: _____

Date: _____