Pediatric Practice Dismissal & Continuity-of-Care Form

General Edition

For use when a pediatric practice ends an established physician-patient relationship because of the practice's vaccination policy

Purpose: This form documents the practice's decision, termination date, transition arrangements, continuity-of-care information, and the parent's request for medical records.

Important: This form does not require the practice to agree with the parent's vaccination decision or to certify that its termination is legally valid. The practice may provide its own written termination notice instead. State-specific requirements may apply.

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1. Child and Practice Information

Child's name: _____

Date of birth: _____

Parent / guardian: _____

Practice name: _____

Physician / practitioner: _____

Practice address: _____

Practice phone: _____

Date of conversation / notice: _____

Practice representative: _____

Title / role: _____

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2. Practice-Initiated Termination of Care

The practice has informed the parent / guardian that it is ending the child's established physician-patient relationship.

Reason stated by the practice

- □ Practice vaccination policy requires full vaccination
- □ Parent declined one or more recommended vaccines
- □ Parent requested to delay one or more vaccines
- □ Parent requested an alternative vaccination schedule
- □ Other: _____

Practice's explanation, if provided:

_____

_____

Notice
Date notice was given: _____

How notice was given:

- □ In person
- □ Telephone
- □ Patient portal / electronic message
- □ Regular mail
- □ Certified mail / return receipt
- □ Other: _____

Effective date care will end: _____

Number of days between notice and termination: _____

Written / documented termination notice:

- □ Provided today - copy given to parent
- □ Previously provided
- □ Will be provided by: _____
- □ Practice does not intend to provide a separate notice

_____

3. Transition and Continuity of Care

What care will remain available until the termination date?

- □ Routine pediatric care
- □ Sick visits
- □ Urgent visits
- □ Medication refills, when medically appropriate
- □ Follow-up for existing conditions
- □ Previously scheduled appointments
- □ Pending test / lab follow-up
- □ Other: _____
- □ Practice states no further care will be provided

If the child becomes sick before another practitioner is established, the practice instructs the parent to:

_____

_____

After-hours / urgent-care instructions:

_____

_____

Existing medical needs

The following require attention during the transition:

- □ Pending lab / test result
- □ Prescription / refill
- □ Specialist referral
- □ Follow-up appointment
- □ Chronic condition
- □ Developmental concern
- □ School / daycare / sports medical paperwork
- □ Other: _____

Details / responsibility / deadlines:

_____

_____

_____

_____

4. Assistance Finding Continuing Care

The practice provided:

- □ Names of other pediatric practices / practitioners
- □ Physician referral(s)
- □ Health-system referral resources
- □ Insurance-directory guidance
- □ Medical-society / physician-finder resources
- □ No referral or resource was provided
- □ Other: _____

Suggested practices / practitioners

1. Name: _____ **Phone / website:** _____

2. Name: _____ **Phone / website:** _____

3. Name: _____ **Phone / website:** _____

_____

5. Parent Request for Complete Medical Records

I request a complete copy of my child's medical record for my own files.

This is not merely a request that the record eventually be transferred to another practitioner.

Requester: _____

Relationship / authority: _____

Records requested

- □ Complete medical / health record
- □ Immunization record - separate copy requested
- □ Visit / progress notes
- □ Medication history
- □ Problem list / medical history
- □ Growth charts
- □ Laboratory / test results
- □ Imaging reports
- □ Specialist and consultation records contained in the chart
- □ Consent / refusal forms contained in the chart
- □ Hospital / urgent-care records contained in the chart
- □ Other: _____

Preferred format

- □ Electronic, if available
- □ Paper
- □ Both, if available

Delivery

- □ Patient portal
- □ Secure electronic delivery
- □ Mail
- □ Pickup
- □ Other: _____

Delivery email / mailing address / other information:

_____

_____

Parent / guardian signature: _____

Date: _____

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6. Practice Receipt / Records Plan

Records request received by: _____

Date received: _____

Can the complete record be provided today?

- □ Yes - electronic copy provided
- □ Yes - paper copy provided
- □ Yes - available for download through patient portal
- □ Part provided today; remainder requested
- □ No - request accepted for later fulfillment
- □ Practice requires its own records-request form
- □ Practice declined to accept this request

Expected delivery date: _____

Delivery method: _____

Fee quoted, if any: _____

Records department / contact: _____

Confirmation / reference number: _____

> **General federal note:** Where HIPAA applies, a covered entity generally must act on an access request no later than 30 calendar days after receipt, subject to the rule's extension provisions. State law may require faster access or impose additional requirements. A parent generally may exercise access rights for a minor child when acting as the child's personal representative, subject to state law and recognized exceptions.

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7. Practice Acknowledgment

Please select the statement that applies:

- □ The information above accurately reflects the practice's stated termination and transition arrangements.
- □ The practice is providing its own written termination / transition notice instead.
- □ The practice declines to complete or sign this form.

Practice representative: _____

Title: _____

Signature: _____ **Date:** _____

A signature documents the practice's stated arrangements. It is not intended to require the signer to make a legal conclusion about compliance with every applicable law.

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8. If the Practice Declines the Form

Parent documentation
The practice's refusal to complete this form does not prevent the parent from documenting what happened or submitting the medical-record request.

Date / time form was presented: _____

Person receiving it: _____

Title / role: _____

- □ Practice declined to complete the form
- □ Practice declined to sign the form
- □ Practice provided its own termination notice
- □ Practice states its own notice will follow
- □ Practice declined to provide written / documented notice
- □ Practice accepted the medical-record request
- □ Practice declined to accept the medical-record request
- □ Other: _____

Parent's contemporaneous notes:

_____

_____

_____

_____

Parent / guardian signature: _____ **Date:** _____

_____

General Legal / Ethical Context

The requirements for ending an established physician-patient relationship vary by state and circumstance.

The AMA Code of Medical Ethics states that physicians terminating an established relationship should notify the patient or authorized decision-maker sufficiently in advance to permit the patient to secure another physician and should facilitate transfer of care when appropriate.

Under the federal HIPAA Privacy Rule, covered entities generally must act on an individual's access request within 30 calendar days. Parents generally may exercise access rights for a minor child when acting as the child's personal representative, subject to state law and recognized exceptions.

Use a state-specific VaxCalc edition when available.

This document is educational and organizational. It is not legal advice and does not establish that a particular termination is lawful or unlawful.

Prepared by VaxCalc.org