Request for Release of Medical Records From Children's Care Pediatrics

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I hereby request and authorize *Children's Care Pediatrics* to release information from the medical record of:

Patient's name: _____ D.O.B. _____

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Type of records to be released:

____ Medical Record (includes growth charts, last checkup and immunizations) ***No charge***

____Complete information including but not limited to, diagnosis, doctor's orders, treatments, office notes, laboratory reports, x-ray reports, H&P exam results, medication records and all other data pertinent to the course of treatment. ***$25.00 per patient***

____Billing records ____ Form Other (specify) _____

Forwarding instructions of requested records: ***Please allow 10 business days***

____Fax to: (____)_____ *10 pgs or less* Recipient phone # _____

____Mail to: _____

_____
Name of Practice/Person & Address with zip code

Purpose for requesting medical information:

____Moving ____Insurance change ____Personal ____Legal/Attorney

____Other (specify): _____

All information I hereby authorize to be obtained from this facility will be held in strict confidence. I place no limitation on history of illness or diagnostic and therapeutic information, including any treatment for alcohol, drug use or psychiatric disorders. Any disclosure of medical information by the recipient(s) is prohibited except when implicit in the purpose of this authorization. This consent will expire in 90 days unless I specify an earlier date here: _____

Patient/Guardian signature:_____ Date: _____
_____ Fee paid Date:_____