



PediatriCare Associates

Pediatric and Adolescent Medicine

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please be aware the record release processing fee **must** be paid before records can be sent.

Date: _____

I, _____, do hereby authorize PediatriCare Associates to release all medical records pertaining to the patient(s) listed below:

Patient name(s):

- 1. _____ DOB: _____
- 2. _____ DOB: _____
- 3. _____ DOB: _____
- 4. _____ DOB: _____
- 5. _____ DOB: _____

Be transferred to: _____

_____ Fax Number: _____

Please check the box next to the reason(s) for leaving

- Moving out of the area (List new address on lines below)
- Insurance plan change
- Other, please explain: _____
- Over 21 years of age
- Unhappy with practice

New Address: _____

Please check the box next to the type of records you would like released. Prices may vary depending on your selection.

- Immunizations Only**
- Includes current immunization records and Universal Health Form
- Summary Records (Charges may apply- up to \$25 per patient record)**
- Immunization record, last well child check, last 12 months of sick visits and labs, growth chart and last consult notes from each specialist
- Complete Medical Record (Charges may apply- up to \$50 per patient record)**
- Includes all documents in the patient's chart

**I hereby authorize disclosure of the health information for the above-named patient(s). This authorization is valid for 12 months from the date of signature. I understand that they legally have 30 days to release my records. I also understand that I may cancel this request with written notification but that it will not affect any information release prior to notification of cancellation.

Patient signature required if over the age of 18.

Parent/Guardian Signature: _____ Date: _____

Phone Number: Home: _____ Cell: _____