CHESTERFIELD PEDIATRICS

MEDICAL RECORDS RELEASE FORM

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my child(ren)'s individually identifiable health information as described below. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. There will be a fee for the requested records. Please allow up to 2 weeks for processing.

****PATIENTS 18 YRS + MUST REQUEST THEIR OWN MEDICAL RECORDS****

Patient Name: _____ DOB: ____/____/____

Patient Name: _____ DOB: ____/____/____

Patient Name: _____ DOB: ____/____/____

Records being sent by:	Records being received by:
Sender:	**Receiver:**
Sender address:	**Receiver address:**
Sender address:	**Receiver address:**
Sender phone:	**Receiver phone:**
Sender fax:	**Receiver fax:**

Information to be Disclosed - Check all that Apply:

☐ All Medical Records ☐ Only dates of service, from: ____ /_____/____ to ___ /____/_____

☐ Include Records Brought From Another Office ☐ Include Sensitive Information

There will be a fee of $0.50 per page for the first 50 pages; $.0.25 a page for each additional page:

☐ I would like my child's records mailed. I understand there is an additional $10.00 handling/mailing fee.

☐ I will pick up my child's records

☐ Digital Copy of Records ($25.00 for first record. $15.00 per additional sibling. Postage included in price)

Reason for Release:

☐ Relocating ☐ Changing Doctors ☐ Other _____

Written revocation of this authorization must be sent to the physician's office, ATTN: Privacy Officer. This authorization will expire 2 years from the date below.

_____ _____

Signature of Patient/ Legal Guardian **Date**

_____ _____ _____

Printed Name of Patient/ Legal Guardian **Relationship to patient** **Phone Number**