

ADVANCED PEDIATRICS
Request for Release of Medical/Immunization Records

DATE OF REQUEST _____

Patient's Name _____ Date of Birth _____

Father's Name _____ Account # _____

Mother's Name _____ Daytime Phone # _____

Current Address _____

Previous Address _____

Pick Up _____

For Mailed Records:

Mailing Address _____

Reason for records request:

- _____ moving out of area
- _____ not leaving practice; want a copy for personal files
- _____ changing to another Pediatric office
- _____ child is over 18 years old

Immunization Record Only _____ Complete Medical Record _____ (check one)

*** THE RELEASE OF COMPLETE MEDICAL RECORDS REQUIRES A SIGNED AUTHORIZATION FROM THE PARENT. PATIENTS OVER THE AGE OF 18 MUST SIGN FOR THE RELEASE OF THEIR MEDICAL RECORDS.**

*** THERE WILL BE A CHARGE FOR COPYING RECORDS OF \$20.00 PER PATIENT**

I hereby request that my child's medical records be released by Advanced Pediatrics to the party named above. I understand that this disclosure may include information regarding drug abuse, alcoholism or alcohol abuse, regulated by Federal statute (42 CFR Part 2). I further understand that this disclosure may include information regarding an illness of a sensitive nature.

Parent's Signature _____ Date _____

Patient's Signature _____ Date _____

(Required if patient is over 18 years of age)

For office use only:

Date Completed _____ Initials _____