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: _____

Mail Records: _____
Mailing Address:
_____
_____

Reason for records request:
___ moving out of area
___ not leaving practice (copy of records for personal files)
___ changing to another Pediatrician
___ child is over 18 years old

Immunization Record Only:___ *Summary of Care Record:___ **Complete Medical Record:___**(check one)**

* Summary of Care Record is essential medical information needed to transition care. Summary of Care Record is available free of charge.

****THERE WILL BE A CHARGE OF $20.00 FOR COPYING FULL MEDICAL RECORDS PER PATIENT, NOT TO EXCEED $50.00 PER FAMILY***

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/Patient Signature: _____Date:_____
(Required if patient is over 18 years of age)

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.

For office use only:

Date Completed: _____ Initials: _____