Town Pediatrics, PC

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Medical Records Release

Date: _____

I, _____, authorize the copy and release of Medical Records for

Name: _____ DOB _____

Name: _____ DOB _____

Name: _____ DOB _____

You can receive a copy of Immunizations, Growth Charts and the Last PE (Well Visit) without charge.

Please CIRCLE which type of records you would like: Complimentary OR Complete
Complete records on CD Fee is $10.00
Please indicate if Complete records on CD are ok: YES OR NO
(DOB: 5/24/2010 or before) Complete records on CD Fee is $20.00
Please indicate if Complete records on CD are ok: YES OR NO

THERE IS A FEE TO HAVE THE COMPLETE RECORD COPIED ONTO PAPER

I will tender payment for the cost of copying said records. The cost is based on a fee of $10.00 plus $.50 per page; (**maximum cost $50.00 per child**). I understand that these records must be picked up in person when complete. **Chart copying may take up to 7 to 10 days**. Please allow adequate time for your request to be completed. **To have records mailed, you must provide a mailing address; a postage fee will be charged in addition to the copying fees. After 60 days from request, copies will be destroyed. If records are requested again, fees must be paid in advance.**

If leaving practice, reason for transfer: _____

Please provide new address if moving out of the area:

_____ **Phone:** _____

_____

Signature of person requesting records: _____

DO NOT SIGN BELOW UNTIL RECORDS ARE RECEIVED BY YOU. CHARGES: _____

By signing below, I acknowledge that I have received records that were requested on above section of this form.

_____ _____

Signature of Person picking up records **Date**

OFFICE USE only: Copies picked up in person/ Copies mailed/ Copies faxed/ Copies destroyed

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