

### REQUEST FOR RELEASE OF MEDICAL RECORDS

The purpose of this form is to obtain authorization for use or release of protected health care information. Patients have the right to receive one free copy of their medical records. There will be a charge for any additional requests.

I, \_\_\_\_\_, authorize the entity listed below to release medical records for the following patients.

You may email this completed form to [jgiles@ptpediatrics.com](mailto:jgiles@ptpediatrics.com)

**PLEASE DO NOT FAX MEDICAL RECORDS**

**PATIENT INFORMATION:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

<p><b>Records From:</b></p> <p>_____</p> <p>Doctor or Group Name</p> <p>_____</p> <p>Mailing Address</p> <p>_____</p> <p>City, State &amp; Zip Code</p> <p>_____</p> <p>Phone Number &amp; Fax Number</p>
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<p><b>Records To:</b></p> <p>_____</p> <p>Doctor or Group Name</p> <p>_____</p> <p>Mailing Address</p> <p>_____</p> <p>City, State &amp; Zip Code</p> <p>_____</p> <p>Phone Number &amp; Fax Number</p>
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**INFORMATION REQUESTED:**

\_\_\_\_\_ All health care information, including all mental health records.

\_\_\_\_\_ All Immunization Dates and Growth Charts

\_\_\_\_\_ Health care information relating to the following treatment, condition, or date of treatment:

\_\_\_\_\_

\_\_\_\_\_ Other: \_\_\_\_\_

**For the purpose of:** \_\_\_\_\_ Transfer of Care      \_\_\_\_\_ For Specialist Visit      \_\_\_\_\_ Moving or Relocation

I hereby request and authorize the release of requested health care information from the above named party to the corresponding above named party. This authorization will expire 60 days from the date signed. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to Poole and Thomas Pediatrics.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Guardian

\_\_\_\_\_  
Relation to Patient