Medical Record Release Form

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P: 770-640-8119 F: 770-988-5553

Date:_______________

Name of Child: **Date of Birth:**

________________________________ _____________
________________________________ _____________
________________________________ _____________
________________________________ _____________
________________________________ _____________
________________________________ _____________

Reason for requesting release of records: Moving ☐ Other _____________________

Your child's (children's) medical records are confidential documents. The personal and medical information they contain are guarded by privacy protections as described in the Health Insurance Portability and Accountability Act (HIPAA).

By your signature, you authorize **The Pediatric Place, PC** to release these medical records to you, the person(s) or medical practice, or other institution(s) as listed below.

For preparing, printing and/or mailing these medical records, I agree to pay a sum of: $20.00 for all records available. First copy of immunization records and medical summary page only are free. Additional copies of these are $20.00.

Sincerely,

__________________________________ ______________________________________
(Signature of Parent or Child's Legal Guardian) *(Print Name of Parent or Child's Legal Guardian)*

Please release my child's medical records to:

____________________________ ____________________________
____________________________ ____________________________
____________________________ ____________________________
____________________________ ____________________________

Updated Nov 11, 2017