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Medical Record Release Form

Date: _____

If you have multiple children, please complete one release form per child.

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:

