

Medical Record Request

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION - TRANSFERRING FROM ANDERSON HILLS PEDIATRICS, INC.

(Print) Patient's Name

(Print) Patient's Address

Patient's Birth date

Patient's Home Phone Number

The undersigned hereby authorizes Anderson Hills Pediatrics, Inc. to release the following portions of the medical records of the above named patient. Check the one that applies to the patient:

_____ Immunization records, growth charts, copy of last physical exam, pertinent laboratory, X-ray; test results, and other necessary information. **(THIS DOES NOT INCLUDE RECORDS RECEIVED FROM OTHER PHYSICIANS. PLEASE CONTACT OTHER MEDICAL PROVIDERS TO HAVE THOSE RECORDS FORWARDED.)**

_____ Entire medical record for the period _____ to _____ **(THIS DOES NOT INCLUDE RECORDS RECEIVED FROM OTHER PHYSICIANS. PLEASE CONTACT OTHER MEDICAL PROVIDERS TO HAVE THOSE RECORDS FORWARDED.)**

Anderson Hills Pediatrics, Inc. charges **\$10.00 per chart** in a transfer preparation fee. If your chart has been archived to our off-site storage, there is an **additional \$15.00 charge** to retrieve your information. This is not covered by your insurance

The medical record is needed for the following purpose:

Mail to New Physician Address or Home Address

Pick up medical records at Anderson Office or Amelia Office

I understand that I may REVOKE this release at any time in writing, but the request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever occurs first, EXCEPT to the extent that action has been taken thereon. I also understand that this release may include medical records of treatments for physical abuse and/or emotional illness, including treatment of alcohol and/or drug abuse. I also understand that HIV and Aids related information might be released.

Signature

Relationship to Patient

Date

Witness

Fee Paid: _____

Completed by

Paid by: Visa M/C Discover Check # Cash M/O

Reference # _____