



Medical Record Release Form

Patient Authorization for Use and Disclosure of Protected Health Information

Date of Request: _____

Patient Name(s)	Date of Birth

Requested By: _____

Relationship to Patient: _____

By signing this I authorize _____ to release the Medical Records (Protected Health Information) on the above named child(ren). This Protected Health Information is to be sent to:

Peds First Pediatrics
2799 Route 112, Suite 11
Medford, NY 11763
Ph: 631-732-5222 / Fax: 631-732-6222

Patient/ Parent/ Legal Guardian Signature: _____

Check Below:

Check Medical Information You Want Sent:

- | | |
|--|--------------------------|
| _____ Immunization Records | _____ Imaging Reports |
| _____ Growth Chart | _____ Specialist Reports |
| _____ Hospital Discharge Summaries | _____ Laboratory Results |
| _____ Most Recent Well Visit Encounter Sheet | _____ Entire Chart |

***Please note that some practices may charge up to \$0.75 per page, and as such you may elect not to have your child's entire chart sent, and select only the other options. Specialist reports may often be obtained directly from specialist at no charge to you.