**DOCTORS' PEDIATRIC, P.C.**

# Patient Directed Release of Records Directly to Patient or to a Designated Person

Patient Name: _____

Patient home address (for verification): _____

Patient telephone number (in case we have questions): _____

If moving, please give forwarding address: _____

I hereby request a copy of my medical records, as contained in the designated record set of Doctors' Pediatric, P.C., be made available to me, or a copy provided, consistent with my wishes below. I understand there may be a charge for the copy, which can include the labor costs of preparing the copy, supplies, electronic media, and postage.

Reason for requesting records: _____

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**Section 1. Scope and Format.**

Scope of records requested:

☐ My entire record.

☐ Only a portion of my records (describe): _____

The format of the copy I wish sent is:

_____USB from 2009 to present _____Paper Record

- The format may be paper, electronic or mixed, depending both on how it is maintained, and on your copy format preferences. Please check with our staff to discuss the options available for paper and/or electronic copies. ($10.00 USB per child and $.65 per page for paper record.)

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**Section 2. For Records Going Directly to the Patient.**

☐ I wish the copy sent to me at this address: _____.

- The address may be a street address for mailing and is subject to postage fees.

OR

☐ I will pick up the copy in person.

OR

☐ I wish to inspect the record. (We will arrange a mutually agreeable time for the record inspection.)

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**Section 3. For Records Going Directly to Someone Other Than the Patient.**

**Use this portion only if the patient wants a copy of records sent to directly someone else.**

I direct you to send a copy of my records, as set forth in Section 1 above, to another person, whose name and address I have listed below:

Name and address of person who will receive records:

Name: _____

Address: _____

- The address may be a street address for mailing and is subject to postage fees.

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**Section 4. Patient Signature Required.**

_____ _____

Signature of Patient/Client, or his/her authorized representative, or parent or guardian if a minor, please specify relationship to patient/client.

Date

If a representative signs, describe the representative's authority to act on behalf of the patient:_____

_____

_____