**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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby request a copy of my medical and billing 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 is a charge for the copy, which can include the labor costs of preparing the copy, supplies, electronic media, and postage.

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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:

 \_\_\_\_\_\_\_ Digital format (thumb drive) \_\_\_\_\_\_\_Paper Record

* The charge for copying of records is $15 per child, **payable up-front at the time of the request.**

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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.

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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, Date

or his/her authorized representative, or

parent or guardian if a minor,
please specify relationship to patient/client.

If a representative signs, describe the

representative’s authority to act on

behalf of the patient:

Reason for leaving our practice: