



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.

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.**

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.



DOCTORS' PEDIATRIC, P.C.

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.

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: _____

Reason for leaving our practice:
