

## **Release of Medical Records Request**

Patient Address: Patient Phone: Patient ID: Authorize: (If patient is 18 or over, he/she will have to request records)  Primary care Provider (PCP) or Specialist's Name  Address Phone To Release the above Patient's Medical Records to: (If patient is 18 or over, he/she will have to request records)  New (PCP), Specialist or person Receiving copy  Address Phone By upong this authorization, I authorize the above listed PCP or specialist to disclose certain protected health information [PIII] about the pasient listed above to the New PCP, specialist or person receiving copy. I also understand that I may revoke this authorization at any time in writing, to the address State Debox, provided the Information has not been released.  There is no charge for medical records that are sent from PCP or specialist to the New PCP or specialist.  There will be a monetary charge for medical records that will be sent from PCP or specialist to a patient or a patient's legal guardian, as described below.  (I) Paper S25 and/or (I) Electronic \$25  Lunderstand and agree that I am fauntally responsible for the following fees associated with any request for medical records sent from the PCP or specialist to me, the patient, or to me the patient's legal guardian, as described to the production of this information and pastal charges.  Lunderstand that the charge for an electronic copy: S25 each page for the first 25 pages, then 25 for each page thereafter.  Lunderstand that the where for pages cropy is S1 each page for the first 25 pages, then 25 for each page thereafter.  Lunderstand that the where for an electronic copy: S20 including the cost of encrypted CD  Lunderstand that where one pages cropy is S1 each page for the first 25 pages, then \$25 for each page thereafter.  Lunderstand the charge for an electronic copy: S20 including the cost of encrypted CD  Lunderstand that the page for an electronic copy: S20 including the cost of encrypted CD  Lunderstand that the page for an electronic copy: S20 including the cost of encrypted CD  Lu	Patient Name:	Date of Birth:
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Signature of Patient or Legal Guardian

**Printed Name of Patient or Legal Guardian** 

Date

3142 Horizon Rd, Suite 200 Rockwall, Texas 75032-7814 214-306-4456 (office) 214-306-4457 (fax)

www.northpediatrics.com

Prohibition of re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by law. Any further disclosure is strictly prohibited unless the patient/legal guardian provides specific written consent for subsequent disclosure of this information. These records may be protected by federal regulation