NORTH PEDIATRICS

Release of Medical Records Request

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient Phone: _____ Patient ID: _____

I 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 signing this authorization, I authorize the above listed PCP or specialist to disclose certain protected health information (PHI) about the patient 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 listed below, provided the information has not been released.

There is no charge for medical records that are sent from PCP to 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:

( )Paper $25 and/or ( ) Electronic $25

I understand and agree that I am financially 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:

Copying charges include the cost of supplies, electronic devices, labor related to the production of this information and postal charges.

I understand the charge for paper copy is: $1 each page for the first 25 pages, then $.25 for each page thereafter.

I understand that the charge for an electronic copy: $20 including the cost of encrypted CD

I understand that any records sent to North Pediatrics via correspondence from a specialist or any radiology films will have to be obtained from the specialist not North Pediatrics.

Please indicate the specific information to be released:

( ) Complete medical records – to be requested from a previous PCP or specialist when you are a new patient to pediatric Associates.

( ) other _____

Please indicate any information that you want excluded/not released with your request:

( ) Mental Health Records ( ) Drug/Alcohol Testing/Treatment ( ) HIV Testing ( ) Sexual Assault/Victimization Records

( ) Other _____

Please indicate the reason you are requesting Medical Records to be released:

( ) Personal Copy (Charges apply) ( ) Transitioning to an adult PCP/Specialist ( ) Continuity of Care ( )Change of Insurance

( ) Referral to Specialist ( ) Transitioning to a new PCP

Release or Copy request expire 90 days from signature date ****Please allow up to 30 days for processing****

_____ _____ _____

Signature of Patient or Legal Guardian **Printed Name of Patient or Legal Guardian** **Date**

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