Summer Pediatrics

MEDICAL RECORDS REQUEST

REASON FOR REQUEST:

( ) Transfer to another practice ( ) Legal ( ) Moving out of country/state ( ) Personal

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

I, _____ (name of parent/legal guardian) hereby authorize Summer Pediatrics to release all medical records of my child. I certify that this request is made voluntarily and I understand that Summer Pediatrics will no longer be responsible for providing medical care to my child if I am transferring to another medical practice. If the reason of my request is moving to another country Summer Pediatrics will keep my account available in case I come back to the United States.

Please be aware there is a fee for printing records. $0.45 per page plus an administration fee of $10.00.

Reason for transfer/Request: _____

_____

Signature: _____ Date: _____

Pick Up Information (Sign at time of pick up)

Name of person picking up records: _____

Signature: _____ Date: _____

OFFICE USE ONLY

I have collected $ _____ for administrative fees and records copies.

Name of Office staff: _____

Notes: _____

_____