PediatriCare Associates
Pediatric and Adolescent Medicine

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please be aware the record release processing fee **must** be paid before records can be sent.

Date: _____

I, _____, do hereby authorize PediatriCare Associates to release all medical records pertaining to the patient(s) listed below:

Patient name(s):

1. _____ DOB: _____
2. _____ DOB: _____
3. _____ DOB: _____
4. _____ DOB: _____
5. _____ DOB: _____

Be transferred to: _____

_____ Fax Number: _____

_____

Leaving for the following reason(s):

_____ Moving out of the area (**List new address on lines below**) _____ Over 21 years of age

_____ Insurance plan change _____ Unhappy with practice

_____ Other, please explain: _____

New Address: _____

_____

**I hereby authorize disclosure of the health information for the above-named patient(s). This authorization is valid for 12 months from the date of signature. I understand that they legally have 30 days to release my records. I also understand that I may cancel this request with written notification but that it will not affect any information release prior to notification of cancellation.

Patient signature required if over the age of 18.

Parent/Guardian Signature: _____ Date: _____

Phone Number: Home: _____ Cell: _____

Revised: 06/2023