

Uptown Pediatrics, PC Personal Health Information/Medical Record Release Form

Date of Request _____

Primary Doctor _____

Patient name(s) and DOB(s)

We provide a medical summary which includes general history, consult reports, lab reports, growth charts and immunization history. If you are requesting anything other than mentioned, please indicate below next to other.

() Other _____

I authorize Uptown Pediatrics, P.C. to release the above personal health information to:

Name: _____

Address: _____

Phone: _____

I would like to pick up from the office (Only authorized persons may pick-up records which will require a signature)

Reason for Release/Transfer _____

I understand and agree that I will be charged at the rate of \$1.00 per page for copying/processing in addition to the cost for any postage and handling to forward these records. Records are mailed via certified mail or can be picked up from the office.

Print Name of Patient/Parent/Guardian

Signature of Patient/Parent/Guardian

If you are moving, please provide us with your new contact info in case we need to reach you

Phone # _____

Address _____

Office Use Only

Dr's. Signature _____ Date _____

Number of pages: _____ Charge: \$ _____ Postage: \$ _____ Total: \$ _____

Previous Balance on Acct \$ _____ Referred to _____

Records Prepared By: _____ Date _____