Primary Doctor_____ Date of Request_____

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:

( ) Other _____

Please check the corresponding box if you want us to include information regarding:

[ ] Mental health [ ] Drug/ Alcohol Use [ ] STIs/ HIV related information [ ] Genetic testing

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 $0.75 per page for copying/processing in addition to the cost for any postage and handling to forward these records. Be advised that records may take up to 10 business days to complete.

_____ _____

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 _____