MEDICAL RECORDS REQUEST FORM

PEDIATRIC ASSOCIATES

REQUEST TO RELEASE PROTECTED HEALTH INFORMATION

PLEASE COMPLETE ONE FORM PER CHILD

Patient Name: ____ Date of Birth:_________________________________

Patient Address: _______________________________________ Account /Chart: _______________________________

Street Address

_______________________________________ Phone # _____________________________________

City, State, Zip

For Record Release or Copies: By signing this authorization, I authorize the party listed below to use and/or disclose certain protected health information (PHI) about me / my child. 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.

I authorize:

____

Provider's Name

____

Street Address

____

City, State, ZIP

____

Phone#

To release to

____

New Provider, Specialist, or Person Receiving Copy

____

Street Address

____

City, State, ZIP

____

Phone#

For Patient or Legal Guardian Copy Requests: ( ) Paper and/or ( ) Electronic

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies, electronic devices, labor, and postage related to the production of my information. I understand that the charge for paper copy is: **$1.00 each page for the first 25 pages, then $.25 for each page thereafter. If requesting an electronic copy, the charge is $20 which covers the cost of an encrypted CD. Digital Radiology Image copies onto CD are $10.00.**

Costs for reproducing medical records are in accordance with the FL Administrative Register Rule 64B8-10.003 and F.S. 164.524 ©4.

***Information to be Released/Requested*:** ( ) Complete medical record

Note: When requesting medical records from a previous PCP, please select the **complete medical record** box

( ) Labs -dates: ________________ ( ) X-ray images- dates: __________________ ( ) Other: _______________________

( ) Immunizations

***Information to be Excluded / Not Released*:** ( ) Mental Health Records ( ) Drug/Alcohol Treatment

( ) HIV Testing ( ) Sexual Assault/Victimization Records ( ) Other: ______________________________________

Reason for Record Release: ( ) Personal copy (***see above – charges apply)*** ( ) Over age 21 ( ) Continuity of Care

( ) Change of Insurance ( ) Referral to Specialist ( ) Moving out of state ( ) Leaving Practice

( ) Unhappy due to wait time ( ) Unhappy due to Customer Service

( ) Unhappy with Provider (Please state why) ____

( ) Unhappy with Practice (Please state why) ____

***Inspection requests are valid on the date of signature only / Release or Copy requests 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

Prohibition of Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by law. Any further disclosure is strictly prohibited unless the patient/legal guardian provides specific written consent for subsequent disclosure of this information. These records may be protected by federal regulation (42 CFR, Part 2).