



Children First Pediatrics, PC Pediatric and Adolescent Medicine

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Medical Records/PHI Release Form

Please fill out the information below, sign and date at the bottom. In order to expedite the copying and preparation of these records please make payment in full when completing this form. If you would like these records sent directly to another physician, please provide that information below. If you wish to have the records sent to you, please put the current address or write "Pick-up" if you wish to pick up the records from our office.

There is a \$30 processing fee PER CHILD PER CHART if you are picking up a copy of the records, \$35 to have the records mailed to anyone. If you would like further details regarding the fee, please ask the front desk for the handout on the "Explanation of Costs." Payment must be received prior to processing medical records for release. Copies of records not picked up within 90 days of the original request will be destroyed. Another processing fee will apply if additional records are needed after the 90 day period.

FORM OF PAYMENT: Cash \$ _____ Check \$ _____ Charge \$ _____

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties described below.

Information to be disclosed (circle one): Full Medical Record Shot Record Only
Other (explain): _____

Recipient of the information: _____

The information is being requested for the following reason (if you are leaving the practice, please explain why to help us better serve future patients): circle one:

Leaving the Practice Camp/School For your own records
Other: _____

If leaving please explain why: _____

The authorization shall remain in effect from the date signed below. I will contact the practice every 36 months to update the authorizations on record.

Patient Name: _____ DOB: _____

Signature of Parent/Legal Guardian _____ Date: _____