MEDICAL RECORDS REQUEST

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

I, _____(name of parent/legal guardian) hereby authorize Sound Beach Pediatrics to release the entire medical record to me or my designee as outlined below for my child. I certify that this request is made voluntarily, and I understand that Sound Beach Pediatrics will no longer be responsible for providing medical care to my child if I am transferring to another medical practice. If you are moving to another part of the country (or out of the country), Sound Beach Pediatrics will keep my account available in case I come back to this area. This authorization is valid for one year from the date below. I understand I may revoke this authorization at any time. The information disclosed in response to this authorization may be subject to re-disclosure by you and will no longer be protected under the terms of this authorization or by federal privacy regulations. I understand that treatment is not conditioned on this authorization.

2001 WEST MAIN STREET | SUITE 132 | STAMFORD | CT 06902
TEL: (203) 363-0123 | FAX (475) 619-9855

www.SoundBeachPediatrics.com

Please be aware there is a $20 processing fee for each child (family maximum of $50) based on a calculation of average labor and supply costs. Your records will be provided on a flash drive as an encrypted PDF file (only a parent/legal guardian will be provided the password) or other such format agreed to by you and Sound Beach Pediatrics.

Signature: _____ Date: _____

REASON FOR REQUEST (optional):

( ) Transfer to another practice ( ) Legal ( ) Moving ( ) Personal

PICK UP INFORMATION

Name of person picking up records: _____

Signature: _____ Date: _____

OFFICE USE ONLY

Patient has been informed that access was ( ) granted ( ) denied
I have collected $_____ for this family's health record(s).

Method of Payment: check / credit card (no cash accepted)

Name of Office Staff: _____

Notes: _____

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