



## Medical Record Release Form

Patient Authorization for Use and Disclosure of Protected Health Information

Date of Request: \_\_\_\_\_

Patient Name(s)	Date of Birth

Requested By: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

By signing this I authorize \_\_\_\_\_ to release the Medical Records (Protected Health Information) on the above named child(ren). This Protected Health Information is to be sent to:

Peds First Pediatrics  
3241 Route 112, Suite 7  
Medford, NY 11763

Patient/ Parent/ Legal Guardian Signature: \_\_\_\_\_

Check Below:

Check Medical Information You Want Sent:

- |   |   |
|---|---|
| <input type="checkbox"/> Immunization Records                   | <input type="checkbox"/> Imaging Reports    |
| <input type="checkbox"/> Growth Chart                           | <input type="checkbox"/> Specialist Reports |
| <input type="checkbox"/> Hospital Discharge Summaries           | <input type="checkbox"/> Laboratory Results |
| <input type="checkbox"/> Most Recent Well Visit Encounter Sheet | <input type="checkbox"/> Entire Chart       |

\*\*\*Please note that some practices may charge up to \$0.75 per page, and as such you may elect not to have your child's entire chart sent, and select only the other options. Specialist reports may often be obtained directly from specialist at no charge to you.