Pediatric Associates
OF FAIRFIELD

Medical Record Release Form

Patient's Name: _____ Date of Birth: _____

(Please check one of the following)

Send **TO** ☐ _____

Obtain **FROM** ☐ _____

I'll pick up my records* ☐ _____

*If picking up records in our office - please do so within 30 days. After that time - copies will be shredded.

I authorize Pediatric Associates of Fairfield, Inc. (513-874-9460/fax 513-874-5731), to transfer/receive (as indicated above) all or a specified portion of the medical record of the above named patient. Additionally I grant permission for Pediatric Associates to share information verbally with my new Provider as needed. I acknowledge that I will be responsible for the charges incurred in copying these records. I am aware that authorization includes release of information concerning the treatment of drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological and/or HIV-related conditions.

NO CHARGE for the first copy

Check below what you would like copied:

☐ Immunization record only

☐ Diagnoses and treatment plans for ***entire medical record*** generated by Pediatric Associates

(includes only those portions generated in our office and NOT including records from previous physicians, hospitals, labs, etc.)

☐ Other: (be specific) _____

(please note - there will be a charge for copies of any records NOT generated by our office)

Reason for Transfer: _____

*Parent/Guardian/Adult Patient Name: _____

*Address: _____

*City, State and Zip Code: _____

*Telephone Number: _____

* All information MUST be complete and accurate in order for us to honor request for release of records

_____ _____

Patient (if 18 yrs or older)/Parent/Guardian Signature Date

_____

Relationship to Patient Witness/Date (for office use)

Revised 11-17/ljm