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RECORDS REQUEST

DATE:_____

CHILD'S LAST NAME_____FIRST NAME_____DOB_____

PARENT'S LAST NAME_____FIRST NAME_____DOB_____

ADDRESS_____SOCIAL SECURITY #_____

CITY_____STATE_____ZIP_____PHONE_____

I AUTHORIZE THE FOLLOWING FACILITY TO RELEASE:

FACILITY/CLINIC_____ ____ALL MEDICAL RECORDS

ADDRESS_____ ____ SPECIFIC DATE(S)_____

CITY_____STATE_____ZIP_____ ____OTHER(SPECIFY)_____

PHONE#_____FAX#_____

PLEASE SEND THE INFORMATION TO:

FACILITY/CLINIC/PERSON_____

ADDRESS_____

CITY_____STATE_____ZIP_____

DELIVERY METHOD: PICK UP____MAIL____FAX____ FAX#_____FORMAT: PAPER____DISC____

PURPOSE OF MEDICAL RECORDS RELEASE_____

I UNDERSTAND THAT THIS AUTHORIZATION MAYBE REVOKED BY ME AT ANYTIME, PROVIDED THAT I DO SO IN WRITING PRIOR TO THIS RELEASE HAVING ALREADY BEEN DONE. I ALSO UNDERSTAND THAT MY PROTECTED HEALTH INFORMATION MAYBE DISCLOSED BY THE RECIPIENT AND IS NO LONGER PROTECTED UNDER FEDERAL LAW. THIS AUTHORIZATION WILL EXPIRE IN 6 MONTHS, UNLESS STATED OTHERWISE.

PATIENT SIGNATURE (IF OVER 18)_____DATE_____

PARENT/LEGAL GUARDIAN SIGNATURE_____DATE_____

RELATIONSHIP TO CHILD_____

******IF MEDICAL RECORD IS OVER TEN PAGES PLEASE MAIL. THANKS!**

Office use only: Records sent by_____ Sent Date:_____