Pediatric Consultants of Troy, P.C.

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I _____ herby give my consent to Pediatric Consultants of Troy, P.C. to:

( ) RELEASE THE MEDICAL RECORDS OF:

Patient Information:

Name: _____ DOB: _____ Phone Number: _____

____ *Mail* ____ *Call for Pickup at Troy* ____ *Call for Pickup at Shelby*

Mailing Address: _____

Phone/ Fax Number: _____

( ) RECEIVE THE MEDICAL RECORDS FROM PREVIOUS PHYSICIAN:

Office/ Facility Name: _____ Phone Number: _____

Address: _____

Information to be Released: (X)	**Purpose of Requesting Records: (X)**
□ Entire Medical Records	□ Transferring/ Leaving Practice
□ Immunizations & Growth Grids	□ Insurance Purposes
□ Specific date(s) of service Date(s):_____	□ Personal Information □ Other

There is a 25.00 fee for chart to be copied.
-FEE MUST BE PAID FIRST IN ORDER TO PROCESS REQUEST-
Please allow a **two/four** *week turn-around to receive records*

This authorization shall be effective following the date of the signature. However, I understand that this authorization may be revoked at any given time giving written notice to the above listed Physician or Facility. A photocopy of the authorization shall constitute a valid authorization. The Physician, Facility and their employees are released from legal responsibility or liability for the release of the above information to the extent and authorized herein.

Patient or Representative: _____ **Date:** _____

The recipient of the enclosed information is not authorized the use this patient's medical records for any purpose other than that stated above or to disclose any information from the records to any other person or facility without specific written authorization from the patient to do so.