

Pediatric Consultants of Troy

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Pediatric Consultants of Troy Medical Record Release Form

By signing this form, you are allowing the office to release any/all medical records. I understand that any disclosure of information carries with it the potential for re-disclosure. There is a one-to-three-week turnaround time for all requests from storage unless the chart needs to be rushed. Any records that are printed in the office include a \$10.00 fee/child. For any records that we need to request from storage there is a \$25.00 fee/child. These fees must be paid first before we release records. Please complete the below information.

Patient Name(s): _____ DOB: ____/____/____
 _____ DOB: ____/____/____

I Authorize:

[pick one] Pediatric Consultants of Troy Practice/ Person Below:

Recipient / Provider Name:	
Street Address	
City, State, Zip Code	
Phone/ Fax Number	

To Release To:

[pick one] Pediatric Consultants of Troy Practice/ Person Below:

Recipient / Provider Name:	
Street Address	
City, State, Zip Code	
Phone/ Fax Number	

Please Complete Below:

Information To Be Released:	Purpose of Requesting Records:	Delivery Preference:
<input type="checkbox"/> Entire Medical Records	<input type="checkbox"/> Transferring/ Leaving Practice	<input type="checkbox"/> Fax:
<input type="checkbox"/> Immunizations & Growth Grids	<input type="checkbox"/> Insurance Purposes	<input type="checkbox"/> Mail Home to Release Address
<input type="checkbox"/> Test Results	<input type="checkbox"/> Personal Information	<input type="checkbox"/> Pick Up In Office: Rochester/ Shelby
<input type="checkbox"/> Specific Dates of Service(s)	<input type="checkbox"/> Other	<i>*we cannot email any medical records</i>

Patient/ Legal Guardian Signature

Date