Pediatric Consultants of Troy

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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:**
☐ Entire Medical Records	☐ Transferring/ Leaving Practice	☐ Fax #:
☐ Immunizations & Growth Grids	☐ Insurance Purposes	☐ Mail Home to Release Address
☐ Test Results	☐ Personal Information	☐ Pick Up In Office: Rochester/ Shelby
☐ Specific Dates of Service(s)	☐ Other	☐ Email Address:

_____
Patient/ Legal Guardian Signature Date