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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 \$50.00 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	P: _____	F: _____

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

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

Please Complete Below:
 Emailed records are preferred: office@pedcontroy.com

Information To Be Released:	Purpose of Requesting Records:	Delivery Preference:
<input type="checkbox"/> Entire Medical Records If no chronic conditions/diagnosis, please only provide the last physical wellness exam & growth grids to PCT.	<input type="checkbox"/> Transferring/ Leaving Practice	<input type="checkbox"/> Fax #:
<input type="checkbox"/> Immunizations & Growth Grids only	<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"/> School District, Teacher, School Aid, etc including verbal consent	<input type="checkbox"/> Email Address:

Misc Notes:

Patient/ Legal Guardian Signature _____ Date: _____