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Request for Release of Medical Records

Reason for request: _____ relocation ____closer to home ____age
_____other: please share: _____
_____

This request may include disclosure of information relating to ALCOHOL/DRUG TREATMENT, MENTAL HEALTH INFORMATION, AND CONFIDENTIAL HIV RELATED INFORMATION **only if** patient's/legal guardian's initials are included next to the desired information below.

Initial for: _____ Alcohol/drug treatment info ____ Mental Health info
_____ HIV related information (a separate request form will be needed)

Patient Name: _____ DOB: _____

Address: _____ Phone: _____
_____

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My (my child's) medical records are to be transferred to:
Physician's name: _____
Address: _____
_____
Phone: _____

We recommend a summary record be created which includes: active and inactive issues, immunization history, list of medications, surgeries, family history, social history, growth curves, vitals, current physical exam and last three office visits. A processing fee will be calculated at .75 cents per page. You are welcome to a full copy of records and that would be calculated at the same cost. You may also request a CD and the cost is $6 for full or partial records.

Please check:
_____summary _____full records _____ CD ROM

you may also request specific information: ie., specialist information, please write in:
I would like additional information regarding:_____
_____
_____.

X_____ Date:_____
Signature of Patient/Legal Guardian
(Patient must sign if 18 years or older)

X_____
Print Name