REQUEST FOR RELEASE OF MEDICAL RECORDS

I, _____/_____, hereby
(requestor's name) (relationship to child)
give my consent to Children's Health Partners to release to:

Please select one:

☐ Self

- Pick Up Date: _____
- Or mail to (circle one): current address / new address

☐ _____
(Name of physician, health care facility, etc)

_____
(Street Address)

_____
(City, State, and Zip Code)

For _____ _____
(Child's Name 1) (Date of Birth)

_____ _____
(Child's Name 2) (Date of Birth)

_____ _____
(Child's Name 3) (Date of Birth)

_____ _____
(Child's Name 4) (Date of Birth)

_____
(Street Address – address while in practice)

_____
(City, State, and Zip Code)

I authorize the following specified information to be released (select one):

☐ Immunizations & Growth Charts Only

☐ All Records (Fee per Child)

Reason for release of records:

☐ Moving: _____
(New Street Address)

_____
(New City, State, and Zip Code)

_____
(New Phone Number with Area Code)

☐ Insurance Change

☐ Other: _____

Signature:_____ **Date:**_____

Task Completed Date: _____ Completed by: _____

Fee Collected: $_____ Payment Method: _____ Received by: _____

Revised 7/10/07