Pediatric and Adolescent Medicine

Medical Record Request Form

Please complete

Children's Full Name: _____
First Name *Last Name*

_____
First Name *Last Name*

_____
First Name *Last Name*

Reason(s) for Request:

Please check one or more

☐ **Relocating** ☐ **Visit w/ Specialist** ☐ ***other*** _____

Records to be mailed to:

_____

_____

_____

OR

To be picked up by: _____
Name of Parent, Guardian, Relative, etc.

Please indicate if chart should remain: ☐ Active or ☐ Inactive

***** Kindly allow 7 to 10 business days to process request. *****

By signing this authorization, I authorize West End Pediatrics, P.C. to disclose all protected health information (PHI) contained in my medical records to the recipient named above.

_____ _____
Signature of Parent/Guardian Relationship to Patient

For Office Use ONLY

Records Request received on: _____ Records released on: _____
Date/Initials *Date/Initials*

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