



*Pediatric and Adolescent Medicine*

## Medical Record Request Form

*Please complete*

**Children's Full Names:**

\_\_\_\_\_

*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

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: \_\_\_\_\_ Date/Initials      Records released on: \_\_\_\_\_ Date/Initials

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