Main Street Pediatrics

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS
(PHI – Protected Health Information)

****PLEASE NOTE: Please allow two weeks at least to receive or pick up records after making the request**
There is a $10 per patient processing fee that must be paid prior to release ($40.00 max per family)
We also request that all patient accounts be paid prior to releasing records.**

I Request that Main Street Pediatrics release ALL medical records for the following patient(s):
(This includes information, where applicable, relating to medical treatment, behavioral or mental health treatment, laboratory results, treatment for sexually transmitted diseases or HIV/AIDS)

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Home Address: _____ **Phone:** _____

_____

Please Send Medical Records to:

Home / Physician / Clinic : _____

Street Address: _____

City, State & Zip: _____

Reason for leaving MSP: _____

I understand that I have the right to revoke this authorization at any time and it must be done by submitting a written request to the office manager at Main Street Pediatrics. I understand that the revocation will not apply to information that has already been released. I understand that any disclosure of information carries with it potential for redisclosure and the information may not be protected by federal confidentiality rules.

Parent/Legal Guardian Signature/ 18+ Signature: _____

Print Name of Parent/Legal Guardian/ 18+ Signature: _____

Relationship to Patient: _____ Date: _____