# *Pediatric & Adolescent Medicine, LLP*

## Medical Record Request Form

*Please complete*

**Child/ren'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*** _____

☐ **Insurance Change** *Please indicate name of new insurance*: _____

**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 Pediatric and Adolescent Medicine, LLP 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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