PROSPECT PEDIATRICS

Pamela Biddle, M.D.
Deborah Massey, M.D.
Terence McKenna, M.D.
Patrick Hynes, M.D.

PROSPECT PEDIATRICS
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the release of my medical records **TO / FROM** Prospect Pediatrics: (*circle one*)

TO / FROM (*circle one*) Parent Picking Up Records? **YES / NO** (*circle one*)

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number:_____ Fax Number:_____

Patient's Name and Date of Birth:

_____ DOB:_____

_____ DOB:_____

_____ DOB:_____

_____ DOB:_____

_____ DOB:_____

Records requested _____ Labs / X-rays / Test Results

_____ Entire Medical Record _____ Other _____

In order to improve our practice policies, please tell us why you have requested the release of your child's medical record. I am leaving Prospect Pediatrics because:

_____ I am moving out of the city and will no longer be near your office.
My forwarding address is:_____

_____ I am dissatisfied with this medical practice (*Please use back of form to explain reason.*)

_____ Other _____

May we contact you in reference to the release of these medical records? **YES / NO** (*circle one*)

_____ (*18 years of age and older must sign*)
Printed Parent / Legal Guardian

_____ _____
Signature Parent / Legal Guardian Date

REVOCATION SECTION

_____ _____
Signature Date

PLEASE ALLOW OUR MEDICAL RECORDS DEPARTMENT 1-2 WEEKS TO COPY / MAIL YOUR CHILD'S MEDICAL RECORDS. BY LAW, THE PRACTICE HAS UP TO 30 DAYS.