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**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

REVOCACTION 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.