



Medical Record Request

Date: _____

Name of Person Requesting Records: _____

Address: _____
(Street) (City/Zip)

Relationship to Patient: _____ Phone Number: _____

Reason For the Request

- Relocating
- Change of Insurance
- Transferring Office
- Personal Records
- Aged Out

I hereby authorize the release of my children's medical records:

| Child's Name | Date of Birth |
|--------------|---------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

- Complete Records (fee per office policy) Vaccination Record Only

Record processing may take up to one month from the date of payment.

- Please call, I will pick up records upon completion.
- Please mail records to the following address:

****Please note, we cannot fax records****

I, the undersigned, agree to all the terms listed above.

Parent/Guardian Signature: _____

Patient Signature (over 18): _____

Office Use Only

Reviewed by Dr. Ciufalo _____