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 _____

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