Authorization for Release/Request of Medical Records

Prepayment Charge: There is a charge of $10 per patient for electronic records to be faxed and $25 per patient for records to be printed and mailed or picked up in office.

Patient Name:_____ DOB:_____

Parent/Guardian Name:_____ Phone Number:_____

Address:_____ City:_____ State:_____ Zip code:_____

Please choose one option below

☐ **I authorize Chisholm Trail Pediatrics to Release (transfer out) medical information to:**	☐ **I authorize Chisholm Trail Pediatrics to obtain (transfer in) information from:**
_____ Name of Provider or Facility/or Parent Name	_____ Name of Provider or Facility/or Parent Name
_____ Address, City, State, Zip Code	_____ Address, City, State, Zip Code
_____ Phone #	_____ Phone #
_____ Fax # (must be included along with area code) ☐ **OPTION A**: $10 per child - For electronic Health records sent directly to new PCP ☐ **OPTION B**: $25 per child - for Printed Records to be picked up in the office ☐ **OPTION C**: $25 per child- for Printed Records to be mailed	_____ Fax # (must be included along with area code)

The following information is authorized to be released or obtained: (check one)

☐ All Medical related information.

☐ Other (please specify):_____

_____ _____

Signature of Individual or Legal Authorized Representative Date

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