

REQUEST FOR RELEASE OF MEDICAL RECORDS

I, _____ / _____, hereby
(requestor's name) (relationship to child)
give my consent to Children's Health Partners to release to:

Please select one:

Self

- Pick Up Date: _____
- Or mail to (circle one): current address / new address

(Name of physician, health care facility, etc)

(Street Address)

(City, State, and Zip Code)

For _____ (Date of Birth) _____
(Child's Name 1)

_____ (Date of Birth) _____
(Child's Name 2)

_____ (Date of Birth) _____
(Child's Name 3)

_____ (Date of Birth) _____
(Child's Name 4)

(Street Address – address while in practice)

(City, State, and Zip Code)

I authorize the following specified information to be released (select one):

- Immunizations & Growth Charts Only
- All Records (Fee per Child)

Reason for release of records:

- Moving: _____
(New Street Address)

(New City, State, and Zip Code)

(New Phone Number with Area Code)
- Insurance Change
- Other: _____

Signature: _____ **Date:** _____

Task Completed Date: _____ Completed by: _____

Fee Collected: \$ _____ Payment Method: _____ Received by: _____