



ISLAND KIDS PEDIATRICS, P.C.

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Patient Records Request Form

Patient Name: _____ Date of Birth: _____

I would like to obtain a copy of my (indicate relationship to the Patient) _____
Child/niece/nephew/other

protected health information records at this practice: _____
Name of Practice/physician

Name of Person Making the Request for Records: _____

Obtaining a Copy - I would like to obtain a copy of the following:

- _____ The patient's complete record at this practice.
- _____ The patient's record at this practice for the time period through: _____
- _____ A specific section of the patient's record (please describe): _____

Delivery

I would like to pick up the Patient's copy of records on the following date and time:

Please mail the patient's copy of records to:

- It is our office policy to notify you a **fee of \$5.00 for CD** and a mailing fee which the practice incurs to fulfill your request and we require payment in advance for this service.
- Our practice has the right to deny access, in whole or in part, to protected health information if the records are psychiatric notes, are a matter of national security or public health policy, are part of legal proceedings, were provided by a non-provider under promise of confidentiality concerning their identity, or could place in danger your life or the lives of others.

Signature of Person Making the Request: _____ Date: _____