allied
physicians group
A Partnership for Unparalleled Care
Peds First Pediatrics

Medical Record Release Form

Patient Authorization for Use and Disclosure of Protected Health Information

Date of Request:_____

Patient Name(s)	Date of Birth

Requested By:_____

Relationship to Patient: _____

By signing this, I authorize:

Practice/Doctor Name: _____

Phone and Fax Numbers: _____

to release the Medical Records (Protected Health Information) on the above named child(ren). This Protected Health Information is to be sent to:

Peds First Pediatrics
2799 Route 112, Suite 11
Medford, NY 11763
Ph: 631-732-5222 / Fax: 631-732-6222

Patient/ Parent/ Legal Guardian Signature:_____

Check Below:
Check Medical Information You Want Sent:

_____ Immunization Records
_____ Growth Chart
_____ Hospital Discharge Summaries
_____ Most Recent Well Visit Encounter Sheet
_____ Imaging Reports
_____ Specialist Reports
_____ Laboratory Results
_____ Entire Chart

***Please note that some practices may charge up to $0.75 per page, and as such you may elect not to have your child's entire chart sent, and select only the other options. Specialist reports may often be obtained directly from specialist at no charge to you.