WESTSIDE PEDIATRICS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT'S NAME ____ **DOB** __________
ADDRESS _________________________**APT**_____**CITY**__________**STATE**____**ZIP**__________
HOME PHONE (____) _______________

I hereby authorize Westside Pediatrics P.C. to release the medical records, including laboratory and radiological studies. All transfer forms will be processed within 10 business days and will not be released until full payment is received.

Administrative fees*:

- $25 1st request of records
- $30 2nd request of records
- $35 same-day request of records

<u>MAIL TO (please check one)</u>

❑ **Doctor's Name/Medical Facility** ____

Address __________________________________ City __________State ____Zip ________

Signature of Parent/Guardian _______________________ Date ___________________

❑ **My Current Address**
❑ **My New Address**

Address __________________________________ City __________State ____Zip ________
Home Phone (____) _______________

Signature of Parent/Guardian _______________________ Date ___________________

*Please be aware that an additional fee will be required if your records are stored in an offsite location

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