Request for Release of Medical Records From Georgetown Pediatrics

I hereby authorize Georgetown Pediatrics, P.C. to release the records of:

Patient's Name:_____ DOB:_____

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Type of records to be released:

☐ Medical Records (includes growth charts, last check up, last three office visits, & immunizations if not specified)

☐ Billing Records ☐ Form ☐ Other (specify):_____

Forwarding instructions of requested records:

☐ Fax to:_____ Contact #:_____

☐ Office Pick up Date:_____
(Please allow 10 business days for medical records)

☐ Mail to:_____

_____
Name of Practice/Person & Address

Purpose for requesting medical records:

☐ Moving ☐ Insurance Change ☐ Transferring to adult doctor ☐ Personal ☐ Legal/Attorney

☐ Other (specify):_____

☒ **A valid photo ID, of the legal guardian/patient (18yrs/+) who signed this release, is required for release of medical records.**

☒ **However, a $35.00/per child fee will apply to all requests for medical records.**

_____
Signature of Legal Guardian/Patient (18yrs/+) Date