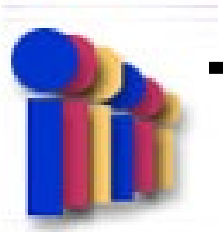

Pediatric & Adolescent Medicine, LLP

Medical Record Request Form

Please fill out the following so that paperwork can proceed in its entirety

***** Kindly allow 7 to 10 business days to process request. *****

Child/ren's Full Name: _____ **D.O.B**:____/___/____
First Name Last Name

_____ **D.O.B:**___/___/____
First Name Last Name

_____ **D.O.B:**___/___/____
First Name Last Name

_____ **D.O.B:**___/___/____
First Name Last Name

Reason(s) for Request:

Please check one or more

_____ **Relocating**

_____ **Aged out**

_____ **Administration Fee**

_____ **Insurance Change** **Please indicate name of new insurance:** _____

_____ **Visit w/Specialist** **Type of specialist:** _____

_____ **Other**

Records to be Mailed to: _____

_____

_____

OR

(Preferred)Fax or Email: _____

Please indicate if chart should remain: _____ Active (staying with the practice)
or _____ Inactive (leaving with the practice)

390 West End Avenue #1E / New York NY 10024 / 212-787-1444 / FAX 866-363-1837
495 Central Avenue #305 / Scarsdale NY / 914-725-7555 / FAX 877-582-1922
www.pedsny.com

By signing this authorization, I authorize Pediatric and Adolescent Medicine, LLP to disclose all protected health information (PHI) contained in my medical records to the recipient named above.

_____ _____ _____

Signature of Parent/Guardian Relationship to Patient Date

MEDICAL RECORD REQUEST OPTIONS

- ***Option 1:*** Medical summary includes: summary of medical history, immunizations, growth chart and last well visit
  No Fee for this option. Please indicate which email/ fax on 1st page

- ***Option 2:*** Paper copy of entire chart. Process is typically 7-10 business days to complete and mail out**.** Fee is $0.75/page for personal copy of medical records
  No fee when directly mailing medical records to new physician
  No fee if email/ fax is preferred, please indicate which email/fax on 1st page

- ***Option 3:*** Flash drive of medical records. Fee is $26.00 per patient
  Please indicate the mailing address on 1st page for the flash drive

- ***Option 4:*** CD of medical records. Fee is $26.00 per patient
  Please indicate the mailing address on 1st page

- ***Option 5:*** Expedited medical records, there is a $30 rush fee added to any of the above options

Please check off which option(s) you choose. Typically, medical records do take 7-10 business days, except for options 1 and 5.

Please complete the information below:

☐Amex ☐Visa ☐Mastercard ☐Discover

Credit Card Number# _____

Expiration Date: ____/_____ CVC/CVV: _____

SPECIFIC UNDERSTANDINGS: I understand that this consent may include disclosure of Alcohol and Drug Abuse records and/or Psychiatric records and/or HIV-related information (indicating that I or my children have had an HIV-related test, or have HIV-related illness or AIDS, or that could indicate that I or my children have potentially been exposed to HIV.) By signing this authorization form, you authorize the use or disclosure of you protected health information as described above. This information may be redisclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations. If you are authorizing the release of HIV-related information, you should be aware that the recipient(s) is prohibited from redisclosing any HIV-related information without your authorization unless permitted to do so under federal or state law. You also have the right to request a list of people who may receive or use your HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights. It is understood that any disclosure is bound by 42 CFR Part 2 governing the confidentiality of alcohol and drug abuse patient records and that redisclosure of alcohol and drug abuse information to a party other than one designated above is forbidden without your additional written authorization.

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