BETHESDA PEDIATRICS

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MEDICAL RECORD RELEASE

Transferring to Internist/Aging Out of Practice

Date: _____

Name: _____ Date of Birth: _____

Contact Phone Number: _____

Information to be Released: COMPLETE CHART IMMUNIZATION RECORD ONLY

How would you like to receive these records? *Please allow up to 7 business days for processing*

___ Pick Up
Date to pick up: _____
If not picking up records myself, I give permission for _____ to pick them up on my behalf.
(Name)

___ Mail to my home or to my new doctor

Address: _____
(Name) (Street Address) (City) (State) (Zip)

By signing below, I agree to allow Bethesda Pediatrics to release my records to the above mentioned party. I also understand that once my records are released, I will no longer be able to be seen at Bethesda Pediatrics for sick care, well care, or immunizations. Bethesda Pediatrics will no longer be my primary care office, and I understand that it is my responsibility to change my Primary Care Doctor with my insurance company and establish myself as a patient with an Internist.

x_____ _____
(SIGNATURE) (PRINT NAME)

$20 FEE PER RECORD
$5 MAILING FEE PER RECORD