

BETHESDA PEDIATRICS

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MEDICAL RECORD RELEASE

Date: _____

Name of Person Requesting Records: _____

Relation to Patient(s): _____

Contact Phone Number: _____

Patient(s) Name(s):

Patient(s) Date(s) of Birth:

Reason:

Information to be Released:

TRANSFERRING TO ADULT M.D.

COMPLETE CHART

MOVING OUT OF AREA

IMMUNIZATION RECORD ONLY

INSURANCE CHANGE

LAB REPORTS ONLY

DISSATISFACTION WITH THE PRACTICE

OTHER: _____

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

Pick Up

Mail

Date to pick up: _____

Address: _____

(Name)

(Street Address)

(City)

(State) (Zip)

X

SIGNATURE OF GUARDIAN (if under 18)

SIGNATURE OF PATIENT (if over 18)

(PRINT)

**\$20 FEE PER RECORD
\$5 MAILING FEE PER RECORD**