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:

TRANSFERING TO ADULT M.D.

MOVING OUT OF AREA

INSURANCE CHANGE

DISSATISFACTION WITH THE PRACTICE

Information to be Released:

COMPLETE CHART

IMMUNIZATION RECORD ONLY

LAB REPORTS ONLY

OTHER: _____

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

___ Pick Up

Date to pick up: _____

___ Mail

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