PC PEDIATRIC CARE OF ROCKVILLE, P.A.

Medical Records/ PHI Release Form

Patient Name: _____ DOB: _____

Signature of Parent/Legal Guardian: _____ Date: _____

In order to expedite the copying and preparation of these records please make payment in full when completing this form. The records will be sent to you on a disc unless otherwise requested.

The fees are as follows: This is based on PER CHILD.

- $7 shipping & handling fee (we send all medical records certified and wit return receipt) to each address requested.
- $20 for the copying to a disc
- $0.74 per page if requesting the records by paper instead of a disc
- Shipping & handling may be more depending on size of chart

Payment must be received prior to processing medical records for release. **Copies of records not picked up within 60 days of the original request will be destroyed.** Another processing fee will apply if additional records are needed after the 60 day period.

FORM OF PAYMENT (Check One): Cash _____ Check _____ Charge _____

FORMAT OF RECORDS (Check One): Disc _____ Paper _____

I hereby authorize you to use or disclose the specific information described below, only for the purpose and parties described.

Please check one: Mail (provide address below) Pick-up (provide contact information below)

Recipient of the information:

Name: _____

Address: _____

Phone number: _____

Relationship to Patient: _____

If you are leaving the practice, kindly please explain why, to help us better serve future patients:

_____

_____

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