AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please be aware that medical records processing fee must be paid before records can be sent

Date:_____

I, _____, do hereby authorize Nuheights Pediatrics to release all medical records to the patient(s) listed below:

Patient name(s):

1._____DOB:_____

2._____DOB:_____

3._____DOB:_____

4._____DOB:_____

Reason for leaving Nuheights Pediatrics (Please check one):
Please note: It is our office policy that once you leave Nuheights Pediatrics will inactive your child's chart.

Moving out of the area:
Insurance plan change:
Other, please explain:

Over 21 years of age:
Unhappy with practice:

New address: _____

_____

Mail or fax records to:_____

_____Fax number: _____

Please indicate if your child's entire chart (please check one):

Entire chart (total fee $6.50 per child)
Copy of immunization record and most recent well visit

**I hereby authorize disclose of the health information for the above named patient(s). This authorization is valid for 12 months from the date of signature. I under that they legally have 30 days to release my records. I also understand that I may cancel this request with written notification but that will not affect any information prior to notification of cancellation.

Parent/Guardian Signature:_____

Phone number to call when records are ready:_____