Giving Tree Pediatrics Medical Records Release

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Please be advised that I would like to have my child(ren)'s medical records transferred. I hereby authorize you to release copies of the medical records for:

Name of Child(ren) DOB

_____ _____

_____ _____

_____ _____

_____ _____

Reason for Request: _____

Name of Parent or Guardian: _____ Date of request:_____

Parent's/Patient's Signature: _____

I will pick up the records: (check here if picking up records) _____

Please send the records to (specify address for mailing):
_____

Please be advised that there is a $15 administrative fee <u>per chart</u> for preparing copies of records for transfer. ***If you want the records mailed, there is an additional cost of $10.

Date records picked up/mailed: _____ Fee paid by: cash check credit card

Signature of person picking up records: _____

Printed name: _____