COLUMBIA PEDIATRICS
MEDICAL GROUP, INC.
©

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Medical Records Request and Release

For: ____ Date of Birth______________

____ Date of Birth______________

____ Date of Birth______________

1. (**Select one**)

[ ] I hereby authorize the Agent listed below **to disclose/send to Columbia Pediatrics Medical Group, Inc.**, the medical records for the stated individual(s).

[ ] I hereby authorize Columbia Pediatrics Medical Group, Inc., **to disclose/send to the Agent listed below** the medical records for the stated individual(s).

Agent Name: ____

Street Address: ____

City/State/ZIP: ____

Contact Phone: ________________________ Fax Number: ________________________

2. Please send:

[ ] All Medical Records

[ ] Medical Summary

[ ] Other:____

For the purpose of:

[ ] Continuing Medical Care

[ ] Other:____

I understand that I have a right to receive a copy of this authorization upon my request and that a fee is charged to me for these medical records. I acknowledge that payment should accompany this request.

______________________________ Patient Street Address: ______________________________

Signature (Patient, or Parent/Guardian of Patient who is a minor)

Patient City/State/ZIP: ______________________________

______________________________ Patient Phone Number: ______________________________

Print Name / Date Signed

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