BIDABADI Pediatrics

Authorization for Release of Medical Records

I,_____, hereby authorize Bidabadi Pediatrics to release my child(ren)'s medical records to the following provider/practice:

To: _____
(Provider/Practice Name)

_____
(Address)

_____
(Phone and Fax Number)

Patient Information:

Child 1: Name:_____ Date of Birth:_____/_____/_____

Child 2: Name:_____ Date of Birth:_____/_____/_____

Child 3: Name:_____ Date of Birth:_____/_____/_____

Information to be disclosed: I authorize the release of the following health information: (check applicable box below)

☐ ALL of my child(ren)'s health information, including information relating to any medical history, mental or physical condition, and any pertinent treatment received. **I understand that by agreeing to have my child(ren)'s entire medical record sent I will be REQUIRED to pay a copying fee of $1 per page of up to a maximum of $50, per child.** An additional fee may be applied for the mailing of records.

☐ My child(ren)'s BASIC medical record. I understand that by agreeing to have my child(ren)'s basic medical record sent; the new provider will only receive their vaccination record, growth charts, and most recent physical exam.

Phone number of person requesting records: (_____) _____-_____

Bidabadi Pediatrics will contact the above person when the records are processed and ready for collection. At that time, if payment is required, the responsible party will be notified of the total amount due for records. **Please note: if you are requesting an ENTIRE medical record they must be picked up in our office or you may elect to have them mailed to the new medical provider. WE WILL NOT FAX OR EMAIL ENTIRE MEDICAL RECORDS.**

By signing below, I represent and warrant that I have the authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. I agree to any payment required for the obtainment of medical records and will ensure all necessary fees are collected before the release of the above medical records to my child(ren)'s new medical provider.

_____ _____ _____
(Parent/Guardian Signature) (Printed Parent/Guardian Name) (Date)