SOUND BEACH
PEDIATRICS
41° 02' 56"N | 73° 33' 50"W

MEDICAL RECORDS REQUEST

(Children <18y)

Today's Date: _____

Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____

I, _____ (name of parent/legal guardian) hereby authorize Sound Beach Pediatrics to release the entire medical record to me or my designee as outlined below for my child/children. I certify that this request is made voluntarily, and I understand that Sound Beach Pediatrics will no longer be responsible for providing medical care to my child if I am transferring to another medical practice. If you are moving to another part of the country (or out of the country), Sound Beach Pediatrics will keep my account available in case I come back to this area. This authorization is valid for one year from the date below. I understand I may revoke this authorization at any time. The information disclosed in response to this authorization may be subject to re-disclosure by you and will no longer be protected under the terms of this authorization or by federal privacy regulations. I understand that treatment is not conditioned on this authorization.

Please be aware there is a $20 processing fee based on a calculation of average labor and supply costs. Your records will be provided after payment. Your records will be sent as an encrypted PDF file (only a parent/legal guardian will be provided the password) or other such format agreed to by you and Sound Beach Pediatrics.

Signature: _____ Date: _____

REASON FOR REQUEST (optional): ( )Transfer to another practice ( )Legal ( )Moving ( )Personal

2001 WEST MAIN STREET | SUITE 132 | STAMFORD | CT 06902
TEL: (203) 363-0123 | FAX (475) 619-9855

www.SoundBeachPediatrics.com

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PICK UP INFORMATION

Name of person receiving records: _____

Email address: _____

Medical Record Format: ( ) PDF encrypted file ( ) Flash Drive ( ) Hard Copy

Signature: _____ Date: _____

OFFICE USE ONLY

Patient has been informed that access was ( ) granted ( ) denied
I have collected $_____ for this family's health record(s).

Method of Payment: credit card (no cash accepted) Date of Payment: _____

Name of Office Staff: _____

Office Notes: _____

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