

# Genesis Pediatrics, LLC

## Request for Release of Medical Records

**Reason for request:**  Transfer Medical Records  Inspect Medical Records  Other

This request may include disclosure of information relating to ALCOHOL/DRUG TREATMENT, MENTAL HEALTH INFORMATION, and CONFIDENTIAL HIV-RELATED INFORMATION only if Patient's/Legal Guardian's initials are included next to the desired information below.

**Initial for:**  Alcohol/Drug Treatment  Mental Health Information  HIV-Related Information

Patient Name(s): \_\_\_\_\_ Date(s) of Birth: \_\_\_\_\_  
 \_\_\_\_\_

Patient Address: \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Street  
 \_\_\_\_\_  
 City, State Zip

My children's medical records are to be transferred to: \_\_\_\_\_  
 Physician Name  
 \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Address \_\_\_\_\_  
 \_\_\_\_\_  
 Fax Number \_\_\_\_\_ City, State Zip \_\_\_\_\_

Reason for Transfer \_\_\_\_\_

We recommend a summary medical record be created which includes: growth charts, immunizations, allergies, current medication list, labs, x-rays, specialist reports of last 12 months, most recent physical, and the last 3 office visits. A processing fee will be calculated at the rate of \$0.75 per page up to a maximum of \$10 per patient. Charge may be waived for patients aging out of pediatrics and transferring records directly to an adult physician. Request will be processed once payment is received; please contact the office to make payment arrangements.

\_\_\_\_\_  
 Signature of Patient/Legal Guardian Date \_\_\_\_\_  
 \_\_\_\_\_  
 Print Name of Patient/Legal Guardian Records will be picked up:  Yes  No  
 Name to be picked up by: \_\_\_\_\_

(Copies of a complete record are available upon request subject to processing fees. Processing fee will be calculated at the rate of \$0.75 per page with a maximum of \$50.00 per patient)

<b>FOR INTERNAL PURPOSES ONLY:</b>			
Request Received: Date _____	INIT _____	Request Processed: Date _____	INIT _____
# Pages _____	Amount Paid _____	Delivered By: P/U Mail Fax	Date _____ INIT _____
Family Contacted: Date: _____	INIT _____	Added to Patient Transfer Form	INIT _____
<b>Picked-up by</b>		<b>Signature:</b> _____	
<b>Printed Name:</b> _____			
Additional Notes: _____			