Mount Pleasant Pediatrics, P.A.

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Authorization for Release of Medical Records

To Our Patients: There is a **$20.00** fee per child for the records, to be paid at the time of this request. Requested records are solely those of Mount Pleasant Pediatrics. We are only able to provide records from our office.

All Record Must Be Mailed in

Name of Patient _____ Phone _____
Address _____ Date of Birth _____
City, State, Zip _____

Records Released From

Name of Practice_____ Phone _____
Address _____ Fax_____
City, State, Zip _____

Records Released To

Name of Practice_____ Phone _____
Address _____ Fax_____
City, State, Zip _____

Purpose of Disclosure:

__ Moved/Change of Address __Dissatisfaction with Staff __Change of Insurance
__Dissatisfaction with Doctor __Location Inconvenient __Referral to Specialist
__Dissatisfaction with Treatment __Waiting Time Too Long __Continuing Care

Authorization:

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancelation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization. **I understand that there will be a charge for this service and that I am financially responsible for the above request.**

_____ _____
Signature of Individual or Guardian or Personal Representative of Patient's Estate Date