KIDS FIRST PEDIATRICS

growing families one kid at a time

MEDICAL RECORDS RELEASE FORM

Patient Last Name:_____ First Name:_____ DOB:_____

Additional siblings: _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

Address: _____ Phone: _____

I, the undersigned, hereby authorize:

Practice Name:

Address:_____

Phone*_____ Fax*_____

To provide my medical record information to:

Practice Name: **Kids First Pediatrics, PC**

Address: 6312 Hwy 41A, suite 102; Pleasant View, TN 37146

Phone* (615)819-5431 **Fax* (931)245-2820**

- Date(s) of Service requested: _____
- I understand that the entire medical record, including information pertaining to drug or alcohol abuse and psychological or psychiatric treatment, will be provided unless I specify that the following information should not be released:

  _____

  I am requesting a copy of my child's/children's medical records due to

  - ☐ Relocation
  - ☐ Transferring to a different office
  - ☐ Aging out of practice
  - ☐ Insurance change
  - ☐ Personal use
  - ☐ Other: _____

Comments: _____

I understand that I have a right to receive a copy of this authorization upon request.

Patient/Guardian Signature: _____ Date: _____