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

MEDICAL RECORDS REQUEST

Today's Date: _____

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 medical records as outlined below for my child. 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.

Please be aware there is a flat **$20 processing fee for each child (family maximum of $50)**. Your records will be provided on a flash drive 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

Pick Up Information

Name of person picking up records: _____

Signature: _____ Date: _____

OFFICE USE ONLY

Patient has been informed that access was ____granted ____denied.
I have collected $ _____ for the this family's health record(s).
Method of Payment: check / credit card (no cash accepted)

Name of Office Staff: _____

Notes: _____

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