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RECORD REQUEST FORM

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I certified that I am the patient's legal guardian and request medical records be sent to me:

Legal Guardian: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I request the records be: MAILED (Additional Charges Apply) I WILL PICK THEM UP

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information

Summary suitable when transferring to a new practice (patients transferring to a new practice are allowed one record summary free of charge; note this is different and more robust than our standard school/camp form that we also provide free of charge to established patients as needed)

Other: _____

I understand and agree that I am financial responsible for the copying charges, including the cost of supplies and labor, and postage related to the production of the information. I understand the charge for this service is:

- **\$.50 per page for the copying costs of the first 100 pages of medical record**
- **\$.25 per page in excess of 100 pages**
- **A minimum charge of \$15**
- **\$15 is due at the time of the request**
- **Any additional charges owed must be paid before the copies are released to me**

Patient or Legal Guardian Signature

Date Signed

Record Requests Can Take Up To 30 Days From the Date Received at Performance Pediatrics