



MEDICAL RECORDS REQUEST AND RELEASE

Patient Name: _____ Date of Birth: _____

1. Authorization Direction (Select one)

- SENT TO** Grossmont Pediatrics **FROM** the following Agent
- SENT BY** Grossmont Pediatrics **TO** the following Agent

Agent Name: _____

Street Address: _____

City/State/ZIP: _____

Contact Phone: _____ Fax Number: _____

2. Records to Send (Select all that apply)

- All Medical Records
- Medical Summaries
- Other: _____

3. Purpose of Disclosure

- Continuing Medical Care
- Other: _____

I understand that I have a right to receive a copy of this authorization upon my request and that a fee is charged to me for these medical records. I acknowledge that payment should accompany this request. This authorization will automatically expire six (6) months from the date signed, unless otherwise indicated or revoked. I understand that I may revoke this consent at any time except to the extent that action has been taken in reasonable reliance upon the document.

Print Name (or Parent/Guardian if minor)

Patient Street Address

Signature

Date

Patient City/State/ZIP

Patient E-mail

Patient Phone Number
