BURGESS PEDIATRICS

PARTNERS:
James A. Cisco, MD
Sarah G. Cueva, MD
Margaret M. Miller, MD MPH

## REQUEST FOR MEDICAL RECORDS RELEASE

**By signing this form, I authorize Burgess Pediatrics to release confidential health information about my child(ren), by releasing a copy of their medical records to the physician/person/facility/entity listed below. I acknowledge that Burgess Pediatrics cannot be responsible for maintaining the confidentially of this data once it leaves this office. This authorization to release confidential medical records is required by state and federal law.**

Release copies of the medical records of: _____ DOB_____

Including:

- ☐ Medical evaluations
- ☐ Vaccination history
- ☐ Growth records
- ☐ Radiology reports
- ☐ Lab reports

Release my child(ren)'s protected health information to the following:

Physician name and Clinic: _____

Name of Person:_____

Address:_____

Phone: _____

Name of individual requesting records release: _____

Relationship to patient: _____

Signature: _____Date:_____

For office use only:

Delivered on _____via: USB ___CD ___Elation ___Fax ___Hard copy to parent/designee_____

Signature/Date at pick up (if hand delivered) _____