Pediatric Associates, Inc.

Records Release Authorization

Date:____/____/20____

If paying by credit/debit card **$20.00** will be applied to the card indicated: __Discover ___Mastercard __Visa

Records will not be released until payment is received.

Card#:_____Exp. Date:_____/_____ Authorization Code:_____

*Signature:*_____ *Date:___/___/202__*

*Name on Card:*_____

I hereby authorize and request the release of information contained in the medical records of:

Patient Name:_____ DOB:____/____/____

(please **PRINT** Last name, First name)

Patient Name:_____ DOB:____/____/____

(please **PRINT** Last name, First name)

Patient Name:_____ DOB:____/____/____

(please **PRINT** Last name, First name)

Patient Name:_____ DOB:____/____/____

(please **PRINT** Last name, First name)

Release From: Pediatric Associates, Inc.
7910 W. Jefferson Blvd.
Ste. 201
Fort Wayne, IN 46804
260-436-3789

Release To:

Medical records will be released in the form of a USB to the parent, patient or legal guardian only. This person will be responsible for forwarding the USB or copies of the medical records to the new physician.

The purpose for disclosure:

- o *Change of doctor due to age
- o Seeing a specialist
- o Moving out of state/city
- o Prefer a physician closer to home/work
- o Disagree with office policies/Unhappy with practice-please explain on back of form
- o Insurance change
- o Personal use
- o DISMISSED DUE TO MISSED APPOINTMENTS OR COLLECTIONS

*I, the undersigned, understand that I may revoke this authorization at any time, in writing, but the request shall remain until revoked or upon the expiration of (60) days, whichever occurs first, except to the extent that action has been taken thereon. I understand that I am giving permission to release medical information which may include treatment for physical and/or emotional illness, pregnancy, genetic testing, communicable diseases, alcohol or drug abuse treatment, and/or HIV, AIDS, or AIDS-related information. I understand that the medical records will be mailed on an unencrypted USB unless otherwise specified above. *(Any patient 18years or older must sign for the release of his/her medical records.)*

O Parent O Patient O Legal Guardian

Signature:_____ Date:____/____/20____

Printed Name:_____

Address: _____

(please print-street address, city, state, zip)

Phone#: _____

**Medical records are legal documents, therefore owned by Pediatric Associates, Inc. Charges for copies of these documents shall be in accordance with the Indiana code 760 IAC 1-71-3 effective November 2005, which states as follows:*

A1. ***$20.00-Electronic copy (entire family)***
A2. *If a person insists that records be provided within 2 working days, an additional **$10.00** fee will be assessed.*
B1. *Minimum $20.00 fee for paper copies (includes pages 1-10)*
B2. *.50 Per page (pages11-50)*
B3. *.25 Per page (for pages 51 and up)*
B4. *Postage fee applicable (PAI waives the postage fee as a courtesy)*

Office USE:
___NO CHARGE-MEDICIAD INSURANCE
___Payment processed by_____