Children First Pediatrics

Authorization to Release Patient Medical Records

I hereby authorize the release of my child / children's Medical Records as follows:

All sections must be completed

Records to be released from / to *(circle one)*:

_____

_____

_____

Ph#_____Fax#_____

Records to be released to / from *(circle one)*:

☐ Dr. Koch ☐ Dr. Applegate ☐ Kirsten

Children First Pediatrics, P.C.

3901 Pine Lake Rd, Suite 210

Lincoln, NE 68516

Office: 402.488.7337 Fax: 402.488.7338

Patient's Complete Name _____ Date of Birth_____

Patient's Complete Name _____ Date of Birth_____

Patient's Complete Name _____ Date of Birth_____

Patient's Address: _____

Street City State Zip

Current Home Phone # _____

Purpose of release: ☐ prefer different provider ☐ prefer different office location ☐ age of children ☐ Insurance issues ☐ treatment referral/ second opinion ☐ moving out of town ☐ other _____

Information will be released in format preferred by office unless specified here ☐ paper copy ☐ digital copy

Office medical records for all patients listed above will be released including immunization record, growth charts and all laboratory reports unless specified otherwise in this section and initialed by parent/guardian.

- I understand that I may revoke this authorization at any time by notifying the providing organization in writing. If I revoked the authorization, it will not have any effect of actions taken prior to receipt of the revocation.
- I understand that the individual/institution that receives the information described above may not be covered by federal privacy regulations, and that the information may be re-disclosed publicly and no longer be protected by those regulations. Children First Pediatrics does not attest to, warrant nor guarantee the accuracy of documents from other health care providers.
- I am aware that all efforts will be made to expedite my request in a timely manner. According to State regulations I am aware that it may take up to 30 days to process this request.
- There is a fee of $20 for medical records going directly to the family for personal use. (Except immunization records).
- A photocopy or facsimile of this form is as valid as the original.

Parent / Guardian Signature: _____

Parent / Guardian Name: (print) _____

Relationship to patient: _____ **Date:** _____