

## Request for Release of Medical Records

Pediatric Associates of Avon  
1115 Ronald Reagan Parkway, Suite 136  
Avon, IN 46123

By signing this form, I authorize you to release confidential health information about the listed patient(s) by releasing a copy of the medical records, or a summary or narrative of the protected health information, to the physician/person/facility/entity listed below.

I request the medical record(s) of my child/children be released from Pediatric Associates of Avon for the purpose of: \_\_\_\_\_

Please release the following:

Lab Reports	X-ray Reports	Immunizations
Provider notes	Complete Medical Record	Other(specify)

Child's Name

Date of Birth

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I agree to pay the standard fees for the transfer of these record(s).

Parent/Guardian: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient(s): \_\_\_\_\_

Release Records to: \_\_\_\_\_

Address: \_\_\_\_\_

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There is a fee of \$25.00 per child to cover the cost of photocopying the records and postage. If you have an outstanding balance you will need to contact our billing office (317-536-5449) to make payment arrangements before your records will be released.

