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: _____

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.