Release of Medical Records

I, _____, hereby request and authorize:
(parent/legal guardian's name)

Clown Pediatrics, P.C.
401 Camby Ct.
Greenwood, IN 46142
phone: (317) 881-8737 fax: (317)881-8735

To release and send copies of all medical records in their possession for the below patients:

Patient Name(s):	Date of Birth(s):
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please send records to:

Office and/or Dr. Name:_____
Address: _____
_____

Phone: _____ Fax: _____

Or Medical Records have been released to the parent/legal guardian. _____ Staff Initials

A medical record fee of $10.00 will be charged in advance for all medical records regardless of the reason they are requested. All medical records will be placed on a disc (or USB drive by request). A $10.00 rush fee will be added if records are required within two business days. This fee includes postage.

I agree to the above terms and charges for the records.

_____ _____
Parent/legal guardian's signature Date