Request for Medical Records

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

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

Please release and send copies of <u>all medical records</u> in your possession for the below patients:

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

I am requesting medical records from:

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

I authorize the above named physician to release my PHI to Clown Pediatrics. I understand this release will expire in 60 days from the date signed. Information used or disclosed by the organization that received it is no longer protected by Federal Privacy Rules.

_____ _____
Parent/legal guardian's signature Date