Pediatric Associates of Avon

Request for Release of Medical Records

I request the medical record(s) of my child/children be released from Pediatric Associates of Avon. I agree to pay the standard fees* for the transfer of these record(s).

Child's Name	Date of Birth	Physician
______________________	______________	______________
______________________	______________	______________
______________________	______________	______________
______________________	______________	______________
______________________	______________	______________

Parent/Guardian Printed Name: ____

Parent/Guardian Signature: ____

Relationship to Patient(s): ____

Patient Signature: ____
(if 18 or over)

Date of Request: ____________

Release Records to: ____

Address: ____

____

Mail ____ Pick Up ____ Transferring to a New Office: Yes ____ No ____

Reason for Release ____

***A fee of $6.50 per child to cover the cost of all labor, supplies and any applicable postage. Payment accepted in office, over the phone with a credit card, or by mail with check. Records will not be released until payment is made.**